



Alaska Health Statement Form

Groups of 2-9 Employees

Group Name: _____

Relationship to employee

| | Name | Sex | DOB | Height | Weight |
|--------|------|-----|-----|--------|--------|
| Self | | | | | |
| Spouse | | | | | |
| Child | | | | | |
| Child | | | | | |
| Child | | | | | |

Employee Phone Number: Home () _____ - _____ Cell () _____ - _____

ZIP Code _____

- Is any person to be covered currently pregnant or an expectant parent? Yes No
If yes, who? _____ Expected due date? ____/____/____
- Has any person to be covered had, been told he or she had, been advised to have treatment for, had follow-up visits for, or received treatment for:

| Please Check Each Item Either Yes or No | Yes | No |
|--|-----|----|
| 1. ALCOHOL OR DRUG ABUSE | | |
| a. Alcohol/Chemical/Drug Abuse/Habit | | |
| b. DWI/DUI Violations date(s): _____ | | |
| c. Or other Alcohol or Drug Abuse Disorders | | |
| 2. BLOOD DISORDERS | | |
| a. Anemia/Chronic Fatigue | | |
| b. Coagulation Disorders/Hemophilia | | |
| c. Leukemia | | |
| d. Or other Blood Disorders | | |
| 3. CIRCULATORY | | |
| a. Stroke/Paralysis/TIA/Aneurysm | | |
| b. High cholesterol or triglycerides | | |
| c. High blood pressure | | |
| d. Phlebitis/Blood Clot/Peripheral Vascular Disease | | |
| e. Poor circulation/Edema (hands/feet) Raynauds | | |
| f. Or other Circulatory Disorders | | |
| 4. CONGENITAL CONDITIONS | | |
| a. Birth defect/Congenital Deformities | | |
| b. Or other Congenital Conditions | | |
| 5. EAR, NOSE, THROAT | | |
| a. Chronic Ear/Nose/Throat/Tonsil Condition/Disease/Disorder | | |
| b. Ear infections (# _____ past 12 mo.) tubes/tonsillitis | | |
| c. Nasal Malformation/Deviated Septum | | |
| d. Or other Ear Nose and Throat Disorders | | |

| Please Check Each Item Either Yes or No | Yes | No |
|---|-----|----|
| 6. EYE INJURY/DISORDER | | |
| a. Disease or Injury of Eye/Cataract/Glaucoma | | |
| b. Or other Eye Disorders | | |
| 7. GASTROINTESTINAL CONDITIONS | | |
| a. Appendicitis/Chronic Abdominal Pain | | |
| b. Hiatal Hernia/GERD/Acid Reflux | | |
| c. Hernia (inguinal, umbilical, femoral, scrotal) | | |
| d. Gallbladder/Pancreatic Disease | | |
| e. Stomach Disorders/Ulcer | | |
| f. Colon/Rectum/Intestine/Bowel | | |
| g. Blood in Stool | | |
| h. Colitis/Diverticulitis/Hemorrhoids/IBS | | |
| i. Or other Gastrointestinal Conditions | | |
| 8. ENDOCRINE DISORDERS | | |
| a. Diabetes/Sugar in Urine | | |
| b. Goiter/Nodule/Hyperthyroidism/Hypothyroidism | | |
| c. Adrenal/Pituitary Condition | | |
| d. Or other Endocrine Disorders | | |
| 9. HEART CONDITIONS | | |
| a. Heart/Chest Pain/Angina | | |
| b. Coronary Artery Disease | | |
| c. Heart/Chest Pain/Angina | | |
| d. Heart Murmur/Arrhythmia (irreg. heartbeat) | | |
| e. Or other Cardiac devices such as de-fibrillator or pacemaker | | |

| Please Check Each Item Either Yes or No | Yes | No |
|---|-----|----|
| 10. IMMUNE DISORDERS | | |
| a. AIDS, ARC (Aids Related Complex), HIV positive or enlarged lymph nodes | | |
| b. Or other Immune Disorders | | |
| 11. KIDNEY/BLADDER CONDITIONS | | |
| a. Bladder/Urinary Tract/Incontinence | | |
| b. Kidney/Kidney Stones | | |
| c. Or other Kidney/Bladder Conditions | | |
| 12. LIVER CONDITIONS | | |
| a. Hepatitis A/B/C/Other | | |
| b. Cirrhosis/Liver Failure | | |
| c. Or other Liver Conditions | | |
| 13. MUSCULOSKELETAL CONDITIONS | | |
| a. Back/Neck/Spine—Pain/Strain | | |
| b. Bone/Orthopedic Disorder | | |
| c. Fractures (specify if hardware is present) | | |
| d. Disc problems: Bulging, Herniated, Slipped, Ruptured | | |
| e. Spinal Adjustments/Chiropractic Care (# ___ past year) | | |
| f. Bursitis/Gout | | |
| g. Carpal Tunnel Syndrome/Tendonitis/Repetitive Stress Injury | | |
| h. Muscular Dystrophy/Polio residuals | | |
| i. Foot disorder/Bunions/Bone Spurs/Hammertoe | | |
| j. Joint Disorder/Replacement/Dislocation | | |
| k. Gait Abnormality/Loss of Limb | | |
| l. Inflammation/Chronic Muscle Pain/Decreased Range of motion | | |
| m. Rheumatoid Arthritis | | |
| n. TMJ/Jaw Joint | | |
| o. Osteoarthritis/Osteoporosis/Osteopenia | | |
| p. Lupus, Muscle Injury or Disease, Fibromyalgia | | |
| q. Or other Musculoskeletal Conditions | | |
| 14. MENTAL HEALTH DISORDERS | | |
| a. Mental/Emotional Condition/Depression | | |
| b. Therapy/counseling | | |
| c. Attempted Suicide | | |
| d. Attention Deficit Hyperactivity Disorder | | |
| e. Eating Disorders such as, but not limited to, Anorexia or Bulimia | | |
| f. Or other Mental Health Disorders | | |

| Please Check Each Item Either Yes or No | Yes | No |
|--|-----|----|
| 15. NEUROLOGICAL CONDITIONS | | |
| a. Brain Disease or Injury/Concussion | | |
| b. Chronic Headaches/Migraines | | |
| c. Multiple Sclerosis, Paralysis, Cerebral Palsy | | |
| d. Neurodevelopmental/Cognitive/Motor/Speech Delay | | |
| e. Seizures: Gran Mal/Petit Mal/other | | |
| f. Convulsion/Epilepsy | | |
| g. Or other Neurological Conditions | | |
| 16. ORGAN (PROVIDE 15 YEARS OF HISTORY) | | |
| a. Transplant | | |
| b. Organ Cyst/Tumor | | |
| c. Cancer (specify type, location extent: _____) | | |
| d. Chemotherapy/Radiation Treatment | | |
| e. Or other Organ Disorders | | |
| 17. REPRODUCTIVE SYSTEM CONDITIONS | | |
| a. Reproductive System Disorder/Infertility/Menstrual fibroids, dysmenorrhea | | |
| b. Prostate/elevated PSA/prostatitis (males only) | | |
| c. Testicular: Cyst/Torsion/Lump (males only) | | |
| d. Sexual dysfunction or impotence | | |
| e. Or other Reproductive System Conditions | | |
| 18. RESPIRATORY CONDITIONS | | |
| a. Allergies/Hay Fever (Not mild/seasonal) | | |
| b. Emphysema/Asthma/Chronic Lung Disease (COPD) | | |
| c. Sleep Apnea, Chronic Sleep Disorder, TB/Cystic Fibrosis | | |
| d. Or other Respiratory Conditions | | |
| 19. SEXUALLY TRANSMITTED DISEASES | | |
| a. Genital Herpes/Human Pap. Virus (HPV/genital warts) | | |
| b. Or other STD | | |
| 20. SKIN CONDITIONS | | |
| a. Acne | | |
| b. Cancer | | |
| c. Eczema | | |
| d. Or other Skin Conditions | | |
| 21. OTHER CONDITIONS | | |
| a. Any other conditions not listed above | | |

For every "Yes" answer above please complete the following:

| Question | Name | Condition | Date of onset | Date of recovery | Current treatment |
|----------|------|-----------|---------------|------------------|-------------------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

3. Has anyone to be covered been diagnosed with cancer or malignant tumor in the past 10 years? Yes No
 If yes, who: _____ Date treatment ended: ____/____/____
 Type of cancer: _____ Type of treatment: _____
4. Has anyone to be covered received treatment for alcohol or drug use in the past five years? Yes No
 If yes, who: _____ Was treatment for alcohol, drug use or both: _____
 Confined to a medical or drug rehabilitation facility? Yes No Date treatment ended: ____/____/____
5. Has anyone to be covered been advised or is waiting to have any test or operation performed? Yes No
 If yes, who: _____ Describe test or operation needed: _____
 Has it been scheduled? Yes No If yes, give date: ____/____/____
6. Has anyone to be covered incurred medical expenses in excess of \$10,000 in the past 12 months? Yes No
 If yes, who: _____ Please give reasons, dates and whether the person has recovered:

7. Does anyone to be covered have an ongoing medical condition not listed above? Yes No
 If yes, who: _____ Condition: _____
 Type of treatment: _____
8. Is anyone to be covered the recipient of, or on the waiting list for an organ (heart, kidney, lung) transplant? Yes No
 If yes, who: _____ Which organ: _____
 Date of transplant: ____/____/____ Current treatment: _____
9. Is anyone to be covered currently disabled or receiving disability benefits? Yes No
 If yes, who: _____ Type of disability: _____
 Date of onset: ____/____/____

| Person's name | Medication | Reason for use |
|---------------|------------|----------------|
| | | |
| | | |
| | | |
| | | |

10. Please list all prescription medications currently being taken by each person to be covered:

By signing below, I attest that all the information completed on this form is true and complete and that all the persons listed are eligible for enrollment. I understand that ODS will only use this information as part of the group rate determination process. I further understand that if I have misstated or omitted any information on this form, ODS may reassess the rates charged to my employer or terminate coverage in accordance with the laws of the state of Alaska. I (We) authorize any physician, healthcare provider, hospital, insurance or reinsurance company, or any other third-party source including, but not limited to Medical Information Bureau (MIB) financial institution, Department of Motor Vehicles and Pharmacy vendors, to use and disclose a copy of my protected health information to ODS Health Plan, Inc. for the purpose of enrollment determination or eligibility, claim payments and policy underwriting. I understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality. I understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

Employee Signature: _____ Date: _____