CBIA HEALTH CONNECTIONS

THE POWER OF CHOICE

FAMILY HEALTH STATEMENT

A completed Family Health Statement must accompany your Enrollment Application if your group has 50 or less employees* and is enrolling in CBIA Health Connections. The results of this questionnaire will not affect your medical eligibility.

INSTRUCTIONS

Please type or print.

EMPLOYEE AND DEPENDENTS

- Ensure that all items are completed. Give complete dates and details to all "yes" answers.
- Make a copy for your records.
- If you have any questions, please ask your benefits administrator or agent.
- Give completed questionnaire to your agent along with an enrollment form.

Staple shut for confidentiality.

AGENT:

- Submit the original to CBIA Health Connections with the applicable Enrollment/Change Form.

**Not applicable for groups with more than 50 employees.*

FAMILY HEALTH STATEMENT

Print in ink. Complete both pages of form.

Pending Paperwork Number: _____

CHECK ONE: ☐ New Group ☐ New Employee Add ☐ Existing Employee Change

TO BE COMPLETED BY EMPLOYER

Name of Employer: iTech Solutions, Inc	Employer Address: Street: P.O. Box 726
Policy Number:	City: Farmington
	State/Zip: CT 06034

Applicant's Occupation	Hours worked/week	Date of full time hire

What carrier have you elected:

☒ ConnectiCare ☐ Oxford ☐ Aetna

TO DECLINE COVERAGE, EMPLOYEE MUST COMPLETE THIS AREA

❑ **I DECLINE** to enroll for health coverage due to the existence of other group health coverage

FOR: ❑ Myself ❑ Spouse ❑ Dependent children

If I and/or my dependents decline coverage and desire to participate in the plan at a later date, **I may** have to submit evidence of insurability satisfactory to the insurance company.

Signature of employee: _____ **Date:** _____

TO REQUEST COVERAGE, ANSWER ALL QUESTIONS

If additional space is needed, attach a separate sheet. Complete for all family members applying for coverage.

First Name	Initial	Last Name	Height	Weight	Date of birth MM/DD/YYYY	Sex M/F	Full time student Yes/No—If yes, Name School
Employee:							
Spouse:							

Employee Social Security Number:	Marital status: ❑ Single ❑ Married
Employee Address: Street:	Phone: Work Home
City:	Where would you prefer to be called during the day?
State/Zip:	❑ Home ❑ Work

I hereby represent and agree that all the answers and statements in this request are full, complete and true, to the best of my knowledge and belief and understand that the said answers and statements form the basis upon which insurance will be made effective. I understand that omissions, misrepresentations, or misstatements about medical history could result in the denial of an otherwise valid claim and rescission, voiding, or reformation of insurance.

Date:_____ **Employee Signature:** _____ **Spouse Signature:** _____

Other page of form must be completed.

Employer Name: _____
(please print)

- Are you now actively at work full time (30+ hrs/week)? ❑ Yes ❑ No
- Does your spouse have medical coverage elsewhere? ❑ Yes ❑ No
- Is any person to be insured currently covered under COBRA? ❑ Yes ❑ No
- Is any person to be insured enrolled in Medicare? ❑ Yes ❑ No
  If yes, who: _____ ❑ Medicare A ❑ Medicare B

TO REQUEST COVERAGE, ANSWER ALL QUESTIONS

Details may be submitted via sealed envelope marked "confidential." For "yes" answers, details must be provided. If illness is unlisted, provide details in the row marked "other."

	YES	NO
1. Are you, your spouse, or any dependent to be insured, currently disabled or unable to perform their normal activities? WHO: WHY:	❑	❑
2. Have you, or any dependent, been hospitalized, or been advised to be hospitalized within the past 5 years for any reason? WHO: WHY:	❑	❑
3. Have you, or any dependent, had surgery, or been advised to have surgery within the past 5 years for any reason? WHO: WHY:	❑	❑
4. Are you, or any dependents to be covered, currently pregnant? WHO: Expected delivery date:	❑	❑
5. Is this pregnancy the result of infertility treatment? If yes, please explain:	❑	❑
6. Are you, or any dependents to be covered, currently taking any medication? WHO: WHY: Medication:	❑	❑
7. Have you, or any dependent, had medical expenses in excess of $5,000 in the last 12 months? WHO: WHY:	❑	❑

8. Have you, or any dependent, ever had or has a medical professional told, counseled, or treated you or any dependent for any of the following? Do not include any genetic or family history information (other than specific information requested below) or any information related to genetic services or genetic diseases for which you believe you (or any dependent) may be at risk.

	Yes	No	Person Affected	Diagnosis & Date Diagnosed	Treatment and/or Medication	Degree of Recovery	Name, Address & Phone Number of Physician and/or Hospital
a) Chest pain, heart attack, or other heart condition							
b) Condition/disease of the circulatory system (i.e. blood vessels, phlebitis, leg ulcers)							
c) Cancer, tumor, or lymph node enlargement (indicate type of cancer and location)							
d) Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)							
e) High blood pressure (if yes, provide most recent reading)							
f) Diabetes or disorder of endocrine system or glands (indicate if insulin dependent)							
g) Alcohol or drug use, abuse, and/or dependency							
h) Disease of the kidney, bladder or urinary tract							
i) Crohns, Colitis, diseases of stomach, intestine, esophagus or gallbladder							
j) Disorder of the liver or pancreas							
k) Disorder of the lungs or respiratory system							
l) Organ transplants (if yes, include type and date)							
m) Neurologic problems — disorder of the brain, seizures, epilepsy, central nervous system, stroke or paralysis							
n) Nervous, mental, depression, stress or anxiety-related disorder, eating disorder							
o) Disorder of the blood (including anemia)							
p) Lupus or Arthritis (if yes, indicate type and severity of disability)							
q) Congenital anomalies or disorders							
r) Other (any disease/condition not listed above)							

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