



# Alaska Health Statement Form

## Groups of 2-9 Employees

Group Name: \_\_\_\_\_

### Relationship to employee

	Name	Gender	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? \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Complications/High risk/Multiple births?  Yes  No If yes, explain: \_\_\_\_\_
- 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
<b>1. ALCOHOL OR DRUG ABUSE</b>		
a. Alcohol/Chemical/Drug Abuse/Habit		
b. DWI/DUI Violations date(s): _____		
<b>2. BLOOD DISORDERS</b>		
a. Anemia/Chronic Fatigue		
b. Coagulation Disorders/Hemophilia		
c. Leukemia		
d. Or other Blood Disorders		
<b>3. CIRCULATORY</b>		
a. Stroke/Paralysis/TIA/Aneurysm		
b. High Cholesterol/High Blood Pressure		
d. Phlebitis/Blood Clot/Peripheral Vascular Disease		
e. Poor Circulation/Edema (hands/feet) Raynauds		
f. Or other Circulatory Disorders		
<b>4. CONGENITAL CONDITIONS</b>		
a. Birth Defect/Congenital Deformities		
<b>5. EAR, NOSE, THROAT</b>		
a. Chronic Ear/Nose/Throat/Tonsil Condition/Disease/Disorder		
b. Ear Infections (# _____ past 12 mo.) Tubes/Tonsillitis		
c. Nasal Malformation/Deviated Septum/Other		
<b>6. EYE INJURY/DISORDER</b>		
a. Disease or Injury of Eye/Cataract/Glaucoma		
b. Or other Eye Disorders		
<b>7. GASTROINTESTINAL CONDITIONS</b>		
a. Appendicitis/Chronic Abdominal Pain		
b. Hiatal Hernia/GERD/Acid Reflux		
c. Hernia (inguinal, umbilical, femoral, scrotal)		
d. Gallbladder/Pancreatic Disease		

Please Check Each Item Either Yes or No	Yes	No
e. Stomach Disorders/Ulcer		
f. Colon/Rectum/Intestine/Bowel/Blood in Stool		
h. Colitis/Diverticulitis/IBS/Other		
<b>8. ENDOCRINE DISORDERS</b>		
a. Diabetes Taking insulin? <input type="checkbox"/> Yes <input type="checkbox"/> No    Meds? <input type="checkbox"/> Yes <input type="checkbox"/> No		
b. Goiter/Nodule/Hyperthyroidism/Hypothyroidism		
c. Adrenal/Pituitary Condition		
d. Or other Endocrine Disorders		
<b>9. HEART CONDITIONS</b>		
a. Heart/Chest Pain/Angina		
b. Coronary Artery Disease		
d. Heart Murmur/Arrhythmia (irreg. heartbeat)		
e. Or other Cardiac devices such as de-fibrillator or pacemaker		
<b>10. IMMUNE DISORDERS</b>		
a. AIDS, ARC (Aids Related Complex), HIV positive or enlarged lymph nodes		
b. Or other Immune Disorders		
<b>11. KIDNEY/BLADDER CONDITIONS</b>		
a. Bladder/Urinary Tract/Incontinence		
b. Kidney/Kidney Stones		
c. Or other Kidney/Bladder Conditions		
<b>12. LIVER CONDITIONS</b>		
a. Hepatitis A/B/C/Other		
b. Cirrhosis/Liver Failure		

Please Check Each Item Either Yes or No	Yes	No
<b>13. MUSCULOSKELETAL CONDITIONS</b>		
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/Tendonitis		
g. Carpal Tunnel Syndrome/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		
<b>14. MENTAL HEALTH DISORDERS</b>		
a. Mental/Emotional Condition/Depression/ADHD		
b. Therapy/Counseling/Attempted Suicide		
e. Eating Disorders such as, but not limited to, Anorexia or Bulimia		
f. Or other Mental Health Disorders		
<b>15. NEUROLOGICAL CONDITIONS</b>		
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		

Please Check Each Item Either Yes or No	Yes	No
f. Convulsion/Epilepsy		
g. Or other Neurological Conditions		
<b>16. ORGAN (PROVIDE 15 YEARS OF HISTORY)</b>		
a. Transplant		
b. Organ Cyst/Tumor		
c. Cancer (specify type, location extent: _____)		
d. Chemotherapy/Radiation Treatment		
e. Or other Organ Disorders		
<b>17. REPRODUCTIVE SYSTEM CONDITIONS</b>		
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		
<b>18. RESPIRATORY CONDITIONS</b>		
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		
<b>19. SEXUALLY TRANSMITTED DISEASES</b>		
a. Genital Herpes/Human Pap. Virus (HPV/genital warts)		
b. Or other STD		
<b>20. SKIN CONDITIONS</b>		
a. Acne		
b. Cancer		
c. Eczema		
d. Or other Skin Conditions		
<b>21. OTHER CONDITIONS</b>		
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

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

Person's name	Medication	Reason for use

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 will promptly inform ODS in writing if anything happens before my coverage takes effect that makes this health statement incomplete or incorrect. 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 have the right to revoke this Authorization in writing at any time. If I revoke this Authorization, the information described above will no longer be used or disclosed for the reasons covered by this written Authorization. Any uses or disclosures already made with my permission cannot be taken back. Unless revoked, this Authorization shall be in force and effect for twenty-four (24) months from the date of the signature below. To revoke this Authorization, please send a written statement to ODS Health Plan, Inc., Privacy Office, 601 S.W. Second Avenue, Portland, OR 97204 and state that you are revoking this Authorization. This authorization is a condition of your enrollment in our health plan or your eligibility for benefits. If you decide not to sign this authorization we may decline to enroll you in our health plan, provide benefits and payment for treatment.

I (We) have reviewed and I (we) understand this Authorization.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Spouse Signature: \_\_\_\_\_ Date: \_\_\_\_\_