



IF YOU ANSWER "YES" TO ANY QUESTION, YOU MUST PROVIDE COMPLETE DETAILS IN THE HEALTH HISTORY SECTION.

APPLICANT NAME: \_\_\_\_\_ APPLICANT SOCIAL SECURITY # \_\_\_\_\_

**QUESTIONS, CONTINUED FROM PAGE 1. For "YES" answers, details must be provided below under the "Health History" section.**

**14. Cancer, of any kind** – such as skin cancer, colon cancer, breast cancer, throat cancer, ovarian cancer, uterine cancer, prostate cancer, leukemia, Hodgkin’s disease, lymphatic cancer, bone cancer, bone marrow cancer, any other cancers, tumors, or lymph node enlargement?  Yes  No

**15. Male Reproductive System (all men must respond)**

- a) such as: infertility, low sperm count, impotence, sexual dysfunction, penile or scrotal implant, sexually transmitted disease, herpes, genital warts, undescended testes?  Yes  No
- b) Are you expecting a child or in the process of adoption or surrogate pregnancy with anyone, whether or not listed on this application? If yes, please provide the expected delivery/adoption date: \_\_\_\_\_  Yes  No

**16. Female Reproductive – (all females between ages 10-55 must respond)**

- a) such as breast disorder/cyst, lump, silicone breast implants, fibroid tumors, endometriosis, pelvic pain, menstruation disorders, abnormal/absent or irregular menstrual bleeding, uterine fibroids, ovarian cysts, infertility treatment/services, miscarriages, sexually transmitted disease, herpes, genital warts (HPV)?  Yes  No
- b) Does any proposed female applicant menstruate?  Yes  No  
If yes, indicate if: \_\_\_\_\_ Applicant \_\_\_\_\_ Spouse/Partner \_\_\_\_\_ Dependent(s)  
Name(s): \_\_\_\_\_
- c) Has it been more than 40 days since her/their last menstrual period?  Yes  No  
Name(s): \_\_\_\_\_ Applicant \_\_\_\_\_ Spouse/Partner \_\_\_\_\_ Dependent(s)  
If yes, explain: \_\_\_\_\_
- d) Has any female applicant over age 16 had a pelvic exam/Pap smear?  Yes  No  
If yes, provide the date and result of the last pelvic exam/Pap smear: Name(s): \_\_\_\_\_  
Mo/Day/Yr: \_\_\_\_\_ Normal  \_\_\_\_\_ Abnormal  \_\_\_\_\_
- e) Is any female applicant pregnant, or in the process of adoption or surrogate pregnancy?  Yes  No  
If yes, please provide the expected delivery/adoption date: \_\_\_\_\_

**17. In the last 10 years, has any applicant:**

- a. ever been a candidate for, or a recipient of a bone marrow transplant or organ transplant, including cornea transplant?  Yes  No
- b. been placed on a waiting list and/or registered to donate an organ or bone marrow (excluding DMV donor card)?  Yes  No
- c. ever had any non-malignant (benign) tumor/growth or cysts?  Yes  No
- d. ever been diagnosed with obesity and/or have a problem with weight control?  Yes  No
- e. been a patient in a hospital, clinic, surgicenter, or other medical facility as an inpatient or outpatient (excluding childbirth)?  Yes  No
- f. had health, disability, long-term care or life insurance declined, modified, postponed or rated?  Yes  No
- g. been disabled or unable to perform their normal activities, or require the use of any assistive devices including a wheelchair, walker, portable oxygen, etc.?  Yes  No
- h. been told by a medical professional, or ever been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC) or AIDS-related conditions?  Yes  No
- i. ever smoked or used tobacco?  Yes  No  
If yes, who and for how long? \_\_\_\_\_  
If no longer smoking/using tobacco, date of last cigarette/tobacco use? \_\_\_\_\_
- j. had an abnormal physical exam, laboratory results, X-rays, EKG, MRI, CT Scan, PET Scan, ultrasound, cardiac testing, or been advised to undergo further testing, surgery, consultation or treatment?  Yes  No
- k. had any surgical procedures?  Yes  No

**18. In the past 5 years** has any applicant taken, or been advised to take, any prescription medications or prescription food supplements on a long-term basis (for longer than 1 month)?  Yes  No

**19. In the past 12 months** has any applicant been advised to see a dentist or oral surgeon (excluding routine checkups)?  Yes  No

**20. Has any applicant applying** for coverage had any medical problems which have not been disclosed on this Health Statement?  Yes  No

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(continued on next page)

APPLICANT NAME: \_\_\_\_\_ APPLICANT SOCIAL SECURITY # \_\_\_\_\_

**QUESTIONS, CONTINUED FROM PAGE 2.**

**21. In the past 12 months has anyone been treated for any injuries?** If so, please provide date of injury, first date of treatment, recovery date and detail of injury/accident.  Yes  No

**22. Last doctor visit for any reason**, including routine checkup in the last 3 years (excluding dental or eye exam). Provide information for all applicants.

Name	Reason For Visit	Date of visit	Results	Physician
Applicant				
Spouse/Partner				
Dependent 1				
Dependent 2				
Dependent 3				
Dependent 4				

A detailed explanation must be provided below if you answered "YES" to any question (1-21). NOTE: Simply listing the name of a primary physician or referring to a physician's name will be not be considered a substitute for listing fully detailed answers to the questions. If additional space is needed, you may attach a separate page, which must be signed and dated.

**HEALTH HISTORY:**

Question Number/Ltr.	Person Affected	Condition/Diagnosis	Treatment (surgeries/medication)	Date Treatment Began	Date of Full Recovery	Physician Name, Address & Phone Number

**INSTRUCTIONS: DID YOU REMEMBER TO ...**

- Print clearly, complete all sections, and sign and date the application and underwriting authorization form (ages 18 and older)
- Select your primary care physician and include the 6- or 8-digit Provider ID number?  
(It can be found at [www.connecticare.com](http://www.connecticare.com) – click "Find a Doctor.")
- Attach EFT form with a check marked "Void" (if applicable), or a savings deposit slip?
- Attach Domestic Partner Verification Form or other satisfactory certification as we determine (if applicable)?
- Retain a signed copy for your records?

\* By my signature on Part 1, I certify that the statements made herein and in Part 1 are true and complete to the best of my knowledge and belief. Any health conditions that change after the application is submitted but prior to notice of approval, must be reported to ConnectiCare and will be considered in the final underwriting decision.