SL Healthplans LLC
Self Funded Marketing Experts

Statement of Health

Date Completed: Date of Hire: Employer Name

Coverage Desired: Employee Only ☐ Employee and one or more dependents ☐

Medical Coverage Waived ☐ REASON: Other Coverage ☐ Covered by Spouse ☐ Medicare ☐

Complete the following for ALL individuals to be covered.

Name	Relationship	DOB	SSN	Sex	Height	Weight
	Self (Employee)					
	Spouse					
	Child					
	Child					

ADDRESS:_____ **City**_____ **State**_____ **Zip**_____

MEDICAL INFORMATION

Plan Selection _____

Please check "YES" or "NO" for each item and provide details for all "YES" answers in the space provided.

1. Has any enrolling person ever been diagnosed with, had treatment or medication, had any medical advice, or have symptoms that may indicate any of the following conditions:

	YES	NO		YES	NO
a. Parkinson's disease, Cerebral palsy, or other brain disorder?	☐	☐	b. Diabetes, hypoglycemia or sugar in urine?	☐	☐
c. Disorders of the thyroid, pituitary, adrenal or other endocrine system disorders?	☐	☐	d. Ulcer, diverticulitis, Crohn's disease or other gastrointestinal disorders?	☐	☐
e. Disease of the liver (Cirrhosis or Hepatitis), disorder of the pancreas, kidney, bladder, ureters or urethra?	☐	☐	f. Breast, reproductive organ disorder (infertility), high risk pregnancy or premature delivery?	☐	☐
g. Cardiovascular Disease, Hypertension, or Hyperlipidemia, other cardiac condition, or other vascular condition?	☐	☐	h. Mental/emotional disorder or alcohol/substance abuse?	☐	☐
i. Chest Pain, stroke, transient ischemic attack, or cerebrovascular disorder?	☐	☐	j. Disorders of back or spine?	☐	☐
k. Cancer, tumor(s), multiple myeloma?	☐	☐	l. Rheumatoid Arthritis or other disorders of joints/bones?	☐	☐
m. Myopathy, Muscular Dystrophy, or other diseases of the muscles?	☐	☐	n. COPD, Emphysema, Tuberculosis, Cystic Fibrosis or other respiratory disorders?	☐	☐
o. Cirrhosis or Hepatitis?	☐	☐	p. Spinal cord injury, Multiple Sclerosis, Guillain-Barre or other autoimmune disorders?	☐	☐
q. Leukemia or Hodgkin's Disease?	☐	☐	r. HIV, other immune deficiency, or auto-immune disorder? (Lupus, etc.)	☐	☐
s. Aplastic, Sickle Cell or other anemia?	☐	☐	t. Hemophilia (any type) or other coagulation defect?	☐	☐
u. Major trauma or burn?	☐	☐	v. Other disease, condition or injury not elsewhere disclosed on this statement? (i.e. potential organ transplant candidate)	☐	☐

2. Has any enrolling person been confined in a hospital or other treatment facility for more than 2 days due to injury or sickness (physical or mental) in the past 2 years?..... Yes ☐ No ☐

3. Are you or any dependent (whether enrolling for coverage or not) currently pregnant, experiencing any complications, or currently receiving infertility testing or treatment?..... Yes ☐ No ☐

4. Has anyone enrolling for coverage consulted a specialist, been advised by a physician, had surgery, or been hospitalized for any condition not already indicated above?..... Yes ☐ No ☐

Use this space to provide details to any "YES" answer to questions 1 through 4. If you have high blood pressure, please include your last 3 blood pressure readings.

Person	List Medical Conditions and/or specific treatments. Include any anticipated treatment or surgery.	Dates of Treatment	Medications & Dosages	Recovery Status

5.Is anyone enrolling for coverage currently taking medication (enter details directly below)? YES ☐ NO ☐

Person	Medication Name	Generic RX? Yes or No	Dosage & Frequency of Use	Reason for Prescription

If more space is needed use a separate sheet of paper – sign, date & attach any additional pages.

DECLARATION AND AUTHORIZATION: READ CAREFULLY BEFORE SIGNING

The undersigned does hereby declare to the best of their knowledge and belief that the above answers, statements, and attached information is accurate and complete. The undersigned also understands that failure to disclose information may constitute insurance fraud thereby subjecting them to potential prosecution. The undersigned also authorizes any care provider (person or institution) or other entity to provide any needed information to the Administrator or its medical consultants. I t is therefore understood that this or any subsequently received information may be shared with any institution or person to which the Administrator may reasonably see fit as it may become necessary. A photocopy of this form shall be as valid as the original.

X	X
Employee's Signature	*Spouse's Signature (if enrolling)*
Phone Number:	*Email:*