

F. Medical History

Complete only if you answered yes in section E and enrolling for coverage

Have you or your dependents been diagnosed, treated, received counseling or advice during the past five years for any of the following:
PLEASE CHECK "YES" OR "NO" AND EXPLAIN ALL "YES" ANSWERS. USE AN ADDITIONAL PAGE IF NEEDED.

Cancer/Tumor Lung Breast Liver Colon Leukemia/Lymphoma Melanoma
 Yes No Prostate Kidney Bladder Throat Other: _____
 Patient Name: _____ Date Diagnosed: _____ Treatment: _____
 Date Last Treated: _____ Current Status: _____ Stage/Level: _____
 Treating Physician(s): _____

Heart/Circulatory Varicose Veins Skin Ulcer Phlebitis Stroke Aneurysm
 Yes No Blood Disorder Hemophilia Heart Disease Congestive Heart Failure
 Bypass/Angioplasty (# of vessels involved): _____
 High Blood Pressure (Last 3 readings & dates of readings): _____
 High Cholesterol (Most recent reading & date of reading): _____
 Patient Name: _____ Date Diagnosed: _____ Treatment: _____
 Date Last Treated: _____ Current Status: _____
 Treating Physician(s): _____

Reproductive Current Pregnancy (Due date: _____) Multiples Expected _____
 Yes No Pregnancy Complications (current or past) Infertility Endometriosis
 Breast Disorders Other: _____
 Patient Name: _____ Date Diagnosed: _____ Treatment: _____
 Date Last Treated: _____ Current Status: _____
 Treating Physician(s): _____

Intestinal/Endocrine Gallbladder Liver Disorder Hepatitis B/C Colon Disorder (provide diagnosis)
 Yes No Thyroid Disorder Crohn's/Ulcerative Colitis Diabetes Ulcer
 Chronic Pancreatitis Hiatal Hernia/GI Reflux
 Last Hemoglobin A1C: _____ Fasting Blood Sugar: _____ Other: _____
 Patient Name: _____ Date Diagnosed: _____ Treatment: _____
 Date Last Treated: _____ Current Status: _____
 Treating Physician(s): _____

Brain/Nervous Multiple Sclerosis Paralysis Cerebral Palsy Migraines
 Yes No Parkinson's Disease Alzheimer's Disease Epilepsy (Type & Date of last seizure) _____
 Other: _____
 Patient Name: _____ Date Diagnosed: _____ Treatment: _____
 Date Last Treated: _____ Current Status: _____
 Treating Physician(s): _____

Immune Lupus HIV AIDS Other: _____
 Yes No Patient Name: _____ Date Diagnosed: _____ Treatment: _____
 Date Last Treated: _____ Current Status: _____
 Treating Physician(s): _____

Lungs/Respiratory Asthma Allergies Cystic Fibrosis Emphysema / Chronic Bronchitis
 Yes No Pneumonia Tuberculosis Sleep Apnea Other: _____
 Patient Name: _____ Date Diagnosed: _____ Treatment: _____
 Date Last Treated: _____ Current Status: _____
 Treating Physician(s): _____

F. Medical History Continued

Complete only if you answered yes in section E and enrolling for coverage

Eyes/Ears/ Nose/Throat

Yes No

- Retinopathy Cleft lip/palate Chronic Sinusitis Deviated Septum
 Acoustic Neuroma Glaucoma Cataracts Chronic Ear Infections

Other: _____
 Patient Name: _____ Date Diagnosed: _____ Treatment: _____
 Date Last Treated: _____ Current Status: _____
 Treating Physician(s): _____

Urinary/Kidney

Yes No

- Renal Failure Polycystic Kidney Disease Neurogenic Bladder Kidney Stones
 Prostate Disorder Other: _____

Patient Name: _____ Date Diagnosed: _____ Treatment: _____
 Date Last Treated: _____ Current Status: _____
 Treating Physician(s): _____

Bones/Muscles

Yes No

- Bulging/Herniated Disc Pituitary Dwarfism Spina Bifida Arthritis (Rheumatoid or Osteo)
 Joint Injury Pulled/Strained Muscle Other Back/Neck Disorders

Other: _____
 Patient Name: _____ Date Diagnosed: _____ Treatment: _____
 Date Last Treated: _____ Current Status: _____
 Treating Physician(s): _____

**Mental Health/
Substance Abuse**

Yes No

- Alcoholism Eating Disorder Anxiety/Depression Bipolar/Manic Depression
 Drug Abuse Suicide Attempt Attention Deficit Disorder Other: _____

Patient Name: _____ Date Diagnosed: _____ Treatment: _____
 Date Last Treated: _____ Current Status: _____
 Treating Physician(s): _____

Transplant

Yes No

- Organ: _____ Bone Marrow
 Discussed possible future transplant Surgery Completed (Date: _____)

Patient Name: _____ Current Treatment: _____
 Treating Physician(s): _____

Medication

Yes No

Member/Dependent Name	Medication	Condition	Daily Dosage	Frequency
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Additional medication? Yes No If "Yes," please attach sheet.

Other

Yes No

- Treatment, surgery or diagnostic testing discussed or advised, but not yet done Abnormal test or physical results
 Condition or Congenital Disorder not mentioned above Unexplained Weight Change

Patient Name: _____ Date: _____
 Details: _____
 Treating Physician(s): _____

Tobacco Use

Yes No

- Has anyone on this application smoked or used tobacco products during the past 12 months?

Name(s): _____

Please give the name and telephone number of your current doctor/doctors.

Additional Explanations: Please attach a sheet if additional explanation is needed and indicate which section you are referencing.

G. Other Insurance Information

Only complete this section after section E and if enrolling in coverage

Other than existing employer provided coverages, are you or any of your eligible dependents covered under any of the following other medical insurance coverages:

Source	Who is Covered?	Name of Covered	Effective Date	Name of Carrier	Type of Coverage
Spousal:	<input type="checkbox"/> You <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	_____	_____	_____	<input type="checkbox"/> Medical <input type="checkbox"/> Rx <input type="checkbox"/> Dental
Individual Plan:	<input type="checkbox"/> You <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	_____	_____	_____	<input type="checkbox"/> Medical <input type="checkbox"/> Rx <input type="checkbox"/> Dental
Medicaid:	<input type="checkbox"/> You <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	_____	_____	_____	<input type="checkbox"/> Medical <input type="checkbox"/> Rx <input type="checkbox"/> Dental
Medicare:	<input type="checkbox"/> You <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	_____	_____	_____	<input type="checkbox"/> Medical <input type="checkbox"/> Rx <input type="checkbox"/> Dental

Reason for Medicare eligibility Age 65 or Over Disabled Kidney Disease Date Eligible: _____

Type of Medicare Coverage: Part A (Person(s) Covered: _____)

Part B (Person(s) Covered: _____) Part D (Person(s) Covered: _____)

Have you received a Certificate of Creditable Coverage in the last 15 months? Yes No If yes, please attach the certificate to this application.

H. Employee Agreement/Authorization to Release HIPAA Medical Information

This section must be completed

Agreement: I apply to US Health and Life Insurance Company for coverage. I declare that all of the statements contained in this enrollment form, to the best of my knowledge, are true and correct, and that no material insurance information has been withheld or omitted concerning the past or present state of health of myself or of my named dependents. I understand that the above answers shall be the basis for the Insurer to issue a certificate of insurance. I understand and agree that the Insurer is not bound by any statement made by or to any agent unless documented in this enrollment form. I understand that any misstatements about medical history could result in denial of an otherwise valid claim and voiding or reformation of insurance.

I acknowledge reading the entire completed enrollment form and the insurance agent has explained the coverages, limitations and exclusions, other details of coverage of the insurance applied for, and the underwriting rules and regulations of the Insurer. No agent has authority to bind or alter coverage.

I have read the notice explaining the use of the Medical Information Bureau. I authorize any physician, medical practitioner, hospital, clinic, veterans administration facility, other medical or medically related facility, insurance or reinsurance company, Medical Information Bureau, or Consumer Reporting Agency having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition, including drug or alcohol abuse, and or HIV/AIDS test results or diagnosis and/or treatment of me or my named dependents and other non-medical information of me or my named dependents, to give to US Health and Life Insurance Company or its legal representative, any and all such information.

I understand the information obtained by use of this authorization will be used by the Insurer to determine eligibility for insurance, and eligibility for benefits under any existing policy, for myself and my named dependents. Any information obtained will not be released by the Insurer to any persons or organization, except to reinsuring companies or other persons or organizations performing business or legal services in connection with my application for insurance, for any claims, or as may be otherwise lawfully required or as I may further authorize.

I understand that I may request a copy of this authorization at anytime.

Employee Signature: _____ Date: _____

Spouse Signature: _____ Date: _____

(Required if spouse is enrolling for coverage)



8220 Irving Road • Sterling Heights, MI 48312
1-800-211-1538 • www.ushealthandlife.com

Your Privacy Is Protected

US Health and Life Insurance Company, like other health insurance companies, sometimes evaluates present and past medical history of applicants to determine their eligibility for certain policies.

With US Health and Life Insurance Company, this evaluation is limited to specific insurance policies; and the applications for those clearly show this requirement.

I authorize the use and disclosure of my protected health information as described below:

My protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and that relates to: (i) my past, present, or future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me.

US Health and Life Insurance Company is authorized to use or disclose my protected health information. My protected health information will be used or disclosed only for the purposes of administering the insurance certificate subject of this application.

I understand that if I refuse to sign this authorization that US Health and Life Insurance Company may refuse to enroll me or determine that I am not eligible for benefits.

I understand that I may revoke this authorization at any time by sending a written notification to US Health and Life Insurance Company at 8220 Irving Road, Sterling Heights, MI 48312, and this revocation will be effective for future uses and disclosures of protected health information. I further understand, however, that this revocation will not be effective: (i) for information that US Health and Life Insurance Company already has used or disclosed, relying on this authorization or (ii) if the authorization was obtained as a condition of coverage.

Any information you give USHL or its insurer regarding your insurability will be treated strictly confidential. USHL, or its insurer, may make a brief report on information received with your application to the Medical Information Bureau. (A nonprofit membership organization of life insurance companies that operates an information exchange on behalf of its members. P.O. Box 105, Essex Station, Boston, MA 02112. Phone: 617-426-3660). The Bureau, upon request from a member company to whom you may apply for insurance or to whom a claim for benefits may be submitted, will supply the company with such information. If you ask, the Bureau will arrange disclosure of the information in your file and you may seek to correct any inaccuracy in accordance with the Fair Credit Reporting Act procedures.

For Office Use Only

RECV'D _____ EFF DATE _____ MED _____ CLASS _____

ENT'D _____ DIVISION # _____ DEN _____ LIFE _____