

EMPLOYER AGREEMENT & GROUP APPLICATION

REQUIREMENTS FOR NEW GROUP SUBMISSION:

- 1 A completed **Employer Agreement and Group Application**.
- 2 An **Employee Application for Group Health Insurance** for each employee.
- 3 A full advance deposit of the first month's group premium written on a company check. (This amount will be refunded if the application is not accepted.)
- 4 A copy of the prior carrier's premium billing statement for the period ending as of the desired Cox HealthPlans' effective date. Certificates of coverage are requested for each applicant not appearing on the prior carrier's billing statement. (THE STATEMENT MUST BE MARKED TO INDICATE ANY AND ALL TERMINATIONS AND PART-TIME EMPLOYEES AND INELIGIBLE EMPLOYEES ALONG WITH REASON OF INELIGIBILITY).
- 5 A copy of the Employer's most recent Missouri Division of Employment Security Quarterly Contribution and Wage Report. Applicants requesting coverage must appear on the quarterly report earning the equivalent of the Federal minimum wage. (THE STATEMENT MUST BE MARKED TO INDICATE ANY AND ALL TERMINATIONS, PART-TIME EMPLOYEES, AND INELIGIBLE EMPLOYEES ALONG WITH REASON OF INELIGIBILITY).
Sole Proprietors - we require a copy of the most recent federal income tax return. Income reported must be equivalent to the annual Federal minimum wage.
Partnerships or L.L.C. employees - we require a personal 1040 with each applicant's self employment tax attachment or a K-1 with form 1120 attachment.
It is the responsibility of the business owner/applicant to supply adequate proof of eligibility for group coverage. Lack of proper documentation will result in denial of coverage.
- 6 Anyone waiving coverage due to the other group coverage must supply proof of other coverage (certificate of coverage or copy of current ID card) and a signed waiver.
NOTE: IT IS THE RESPONSIBILITY OF THE EMPLOYER TO PROVIDE ADEQUATE PROOF OF VALID EMPLOYEES FOR PARTICIPATION VERIFICATION UPON REQUEST. LACK OF ADEQUATE PROOF WILL RESULT IN COVERAGE BEING DENIED OR TERMINATED.

SECTION A: EMPLOYER/ASSOCIATION INFORMATION *(Please type or print clearly.)*

1	FULL LEGAL BUSINESS NAME:	DBA:
2	MAILING ADDRESS (Number, Street, City, State, Zip):	
3	PHYSICAL ADDRESS (Number, Street, City, State, Zip):	
4	OTHER LOCATIONS (Number, Street, City, State, Zip):	
5	CONTACT NAME & TITLE:	NAME OF AUTHORIZED OFFICER (if different than contact):
6	TELEPHONE NUMBER:	FAX NUMBER: E-MAIL ADDRESS:
7	LEGAL ENTITY: <input type="checkbox"/> CORPORATION <input type="checkbox"/> SOLE PROPRIETOR <input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> L.L.C. <input type="checkbox"/> OTHER (PLEASE SPECIFY): _____	EMPLOYER TAX ID #:
8	NATURE OF BUSINESS:	NUMBER OF YEARS IN BUSINESS:
9	DID YOU EMPLOY AT LEAST 2 EMPLOYEES ON THE FIRST DAY OF THE PLAN YEAR AND DID YOU EMPLOY AN AVERAGE OF AT LEAST 2 BUT NO MORE THAN 50 ELIGIBLE EMPLOYEES ON BUSINESS DAYS DURING THE CALENDAR YEAR PRECEDING THE REQUESTED EFFECTIVE DATE WITH COX HEALTH SYSTEMS INSURANCE COMPANY AND/OR COX HEALTH SYSTEMS HMO, INC. ?	<input type="checkbox"/> YES <input type="checkbox"/> NO
10	IS GROUP CONSIDERED A GOVERNMENT, SCHOOL, OR CHURCH PLAN THAT IS NOT SUBJECT TO ERISA?	<input type="checkbox"/> YES <input type="checkbox"/> NO
11	IS THIS COVERAGE PART OF A UNION NEGOTIATED CONTRACT?	<input type="checkbox"/> YES <input type="checkbox"/> NO

SECTION B: EFFECTIVE DATE OF COVERAGE

1	REQUESTED EFFECTIVE DATE:	MONTH:	DAY:	YEAR:
<p>The Employer/Group may select either the 1st or the 15th of the month to begin coverage. All enrollment materials must be dated and signed prior to the effective date. Cases submitted later than 10 days prior to the requested effective date may be approved for coverage the next available effective date. In most cases, coverage cannot be backdated.</p> <p>The Employer/Group may request to move the effective date any time prior to approval. If the requested change of effective date is greater than 60 days after the originally requested effective date, a requote and all new applications will be necessary. DO NOT CANCEL YOUR CURRENT COVERAGE UNTIL NOTIFICATION OF ACCEPTANCE IN WRITING HAS BEEN RECEIVED FROM COX HEALTHPLANS.</p> <p>The effective date for employees and dependents already covered by a medical plan and not currently disabled, will be the same as the employer's effective date. Employees who choose not to enroll during their initial eligibility period will be ineligible until the next period of open enrollment at anniversary date or qualifying event.</p>				

SECTION C: AFFILIATED COMPANIES (Legal proof of affiliation must be provided prior to coverage being issued.)

1	IS YOUR COMPANY ELIGIBLE TO FILE A COMBINED TAX RETURN WITH ANY OTHER COMPANY? <input type="checkbox"/> YES* <input type="checkbox"/> NO * IF YES, PLEASE PROVIDE NAME(S): _____ ADDRESS(ES): _____										
2	IS THERE MORE THAN 1 COMPANY TO BE ENROLLED IN THIS PROGRAM? <input type="checkbox"/> YES* <input type="checkbox"/> NO * (If yes, you or your company must have controlling interest of 51%.)										
3	SUBSIDIARIES AND/OR AFFILIATES TO BE COVERED. (If additional space is needed, please use a separate sheet.)										
	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">LEGAL BUSINESS NAME:</td> <td style="width: 30%;">ADDRESS (#, Street, City, State, Zip):</td> <td style="width: 20%;">NATURE OF BUSINESS:</td> <td style="width: 15%;">% INTEREST:</td> <td style="width: 10%;"># EMPLOYEES:</td> </tr> <tr> <td>LEGAL BUSINESS NAME:</td> <td>ADDRESS (#, Street, City, State, Zip):</td> <td>NATURE OF BUSINESS:</td> <td>% INTEREST:</td> <td># EMPLOYEES:</td> </tr> </table>	LEGAL BUSINESS NAME:	ADDRESS (#, Street, City, State, Zip):	NATURE OF BUSINESS:	% INTEREST:	# EMPLOYEES:	LEGAL BUSINESS NAME:	ADDRESS (#, Street, City, State, Zip):	NATURE OF BUSINESS:	% INTEREST:	# EMPLOYEES:
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LEGAL BUSINESS NAME:	ADDRESS (#, Street, City, State, Zip):	NATURE OF BUSINESS:	% INTEREST:	# EMPLOYEES:							

SECTION D: OTHER INSURANCE INFORMATION

1	CURRENT GROUP HEALTH CARE CARRIER: <input type="checkbox"/> NO PRIOR HEALTH COVERAGE	# YEARS WITH CARRIER:
2	CURRENT WORKERS' COMPENSATION CARRIER: <input type="checkbox"/> NO CURRENT WORKERS' COMPENSATION COVERAGE	
	IF WORKER'S COMPENSATION DOES NOT COVER ALL EMPLOYEES INCLUDING OWNERS, PLEASE LIST NAMES OF THOSE NOT COVERED:	REASON:

SECTION E: HEALTH PLAN DESIGN

1	PLAN DESIGN OPTIONS:	COX HEALTH SYSTEMS INSURANCE COMPANY:	COX HEALTH SYSTEMS HMO, INC:
2	LINE OF BUSINESS:	PPO	HMO
3	PLAN TYPE:	<input type="checkbox"/> PARTNERS <input type="checkbox"/> HIGH DEDUCTIBLE HEALTH PLAN <input type="checkbox"/> OTHER	<input type="checkbox"/> SOLUTIONS HMO <input type="checkbox"/> SOLUTIONS HMO W/ POINT OF SERVICE RIDER
4	WILL THIS HEALTH PLAN BE USED IN CONJUNCTION WITH A HEALTH REIMBURSEMENT ACCOUNT (HRA) FUNDING ARRANGEMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		

SECTION F: OPTIONAL HEALTH BENEFITS (Additional premium is required for these options.)

For multiplan packages, the same optional benefits must be purchased for all plans

1	LOSS OR IMPAIRMENT OF SPEECH OR HEARING BENEFIT RIDER	<input type="checkbox"/> ACCEPT	<input type="checkbox"/> DECLINE
2	AMENDMENT TO INCLUDE ELECTIVE ABORTION RIDER	<input type="checkbox"/> ACCEPT	<input type="checkbox"/> DECLINE
3	OTHER (PLEASE SPECIFY)	<input type="checkbox"/> ACCEPT	<input type="checkbox"/> DECLINE

SECTION G: ELIGIBILITY, PARTICIPATION, AND CONTRIBUTION REQUIREMENTS

To be an eligible employee for medical coverage, the employee must work full time, year around, for full pay, at the employer's normal place of business. Retirees are not eligible for coverage unless mandated by the state of Missouri.

Note: Per Missouri Small Group Reform, employees working 30 hours or more are considered eligible employees. Groups consisting of 2-50 eligible employees may not specify an hourly requirements of greater than 30 hours for benefit eligibility.

1	SPECIFY # OF HOURS REQUIRED TO BE ELIGIBLE FOR COVERAGE:	TOTAL # OF ELIGIBLE EMPLOYEES:	TOTAL # OF ENROLLED EMPLOYEES:
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Cox Health Systems Insurance company (CHSIC) and/or Cox Health Systems HMO, Inc. (CHMO) requires the following participation requirements to be met initially and at all times throughout the life of the contract:

A. Employers with 2-9* employees must maintain an enrollment of 75% of all eligible employees**.

B. Employers with 10 or more eligible employees must maintain and enrollment of 75% of all eligible employees**. Employers must also maintain enrollment of at least 60% of the total number of eligible employees.

** Groups must consist of and maintain a minimum of 2 employees to be considered an eligible group. Per Missouri Revised Statute 379.930 "...a person, his spouse and his minor children shall constitute only one eligible employee when they are employed by the same small employer."*

*** If the employee has other group or individual medical coverage and can provide proof of such coverage, they shall not be counted toward this participation requirement. Any person covered under this contract pursuant to COBRA or State Continuation Laws will not be included in the calculation of the participation requirement.*

GROUPS WHO FAIL TO MAINTAIN PARTICIPATION OR DROP TO ONE EMPLOYEE ARE SUBJECT TO TERMINATION.

CHSIC and/or CHMO shall be entitled to rely on the most current information in possession regarding the eligibility of employees. CHSIC and/or CHMO reserve the right to require, at any time, that the company furnish proof that participation is met on an ongoing basis.

2	CLASSES OF ELIGIBLE EMPLOYEES: <input type="checkbox"/> ALL EMPLOYEES MEETING ELIGIBLE HOURLY REQUIREMENT <input type="checkbox"/> ONLY SPECIFIC CLASSES - Additional documentation may be required (Mark all that apply.) <input type="checkbox"/> Owners <input type="checkbox"/> Salaried <input type="checkbox"/> Union <input type="checkbox"/> Independent Contractors <input type="checkbox"/> Management <input type="checkbox"/> Hourly <input type="checkbox"/> Non-Union <input type="checkbox"/> Other (Please specify:) _____
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CONTRIBUTION: Employer/Group is required to pay at least 50% of the employee/member's premium.

3	SPECIFY EMPLOYER/GROUP CONTRIBUTION TOWARDS:	EMPLOYEE PREMIUM: _____ %	DEPENDENT PREMIUM: _____ %
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SECTION H: WAITING PERIOD

1 **WAITING PERIOD** (period of continuous employment before eligible employee may enroll in coverage):
 0 days 30 days 60 days 90 days 180 days OTHER: _____

2 **EFFECTIVE DATE AFTER WAITING PERIOD SATISFIED:** 1st* of following Month Date of Eligibility
 *(Effective date will be 15th of following month if mid-month effective date selected in Section B-1.)
 NOTE: Coverage for terminating employees will end the first service date following date notification is received by plan if '1st* of following Month' effective date is indicated; Coverage will terminate on date of employment termination if 'Date of Eligibility' is indicated, unless otherwise agreed to by the plan.

3 **IS THE WAITING PERIOD ABOVE WAIVED FOR INITIAL ENROLLEES?** YES NO

4 **DO ANY CLASSES OF EMPLOYEES HAVE A DIFFERENT WAITING PERIOD?** YES* NO
 * IF YES, PLEASE EXPLAIN:

SECTION I: CONTINUATION

1 **COBRA OR STATE CONTINUATION:** (Group attests that all eligible continuees have been notified of their right to continue.)

2 **ARE THERE ANY FORMER EMPLOYEES OR DEPENDENTS CURRENTLY COVERED UNDER CONTINUATION?** YES* NO

3 **ARE THERE ANY EMPLOYEES OR DEPENDENTS ELIGIBLE FOR CONTINUATION WHO HAVE NOT YET ELECTED SUCH COVERAGE?** YES* NO

4 **IF YOU ANSWERED YES TO EITHER QUESTION ABOVE, PLEASE COMPLETE THE INFORMATION BELOW:**
 TYPE: C = ENROLLED IN CONTINUATION (We require completion of the employee application.)
 E = ELIGIBLE BUT HAS NOT ELECTED CONTINUATION (We request completion of the Employee Application.)

TYPE:	NAME:	LAST DATE EMPLOYED:	EFFECTIVE DATE OF COVERAGE:	DATE CONTINUATION OFFERED:
C E				
C E				
C E				
C E				

WE AGREE THAT WE HAVE COMPLIED WITH THE COBRA/ERISA REQUIREMENTS AS THEY PERTAIN TO THE ABOVE EMPLOYEES OR DEPENDENTS.

SECTION J: PRODUCER AGREEMENT

1 I HEREBY CERTIFY THAT I HOLD A VALID INSURANCE LICENSE ISSUED BY THE STATE OF MISSOURI AND THAT ALL OF THE INFORMATION CONTAINED HEREIN IS CORRECT TO THE BEST OF MY KNOWLEDGE, AND THAT I KNOW NOTHING UNFAVORABLE ABOUT THE FIRM OR ANY INDIVIDUAL APPLYING FOR COVERAGE, UNLESS FULLY DESCRIBED.
 I CERTIFY THAT ALL PARTICIPATION AND CONTRIBUTION REQUIREMENTS HAVE BEEN MET.
 I CERTIFY THAT ELIGIBILITY PROVISIONS AND LIMITATIONS APPLICABLE TO THIS PROGRAM HAVE BEEN FULLY DISCLOSED TO THE EMPLOYER.

2 **COMMISSION:** PRODUCER AND EMPLOYER/GROUP HAVE AGREED UPON THE FOLLOWING COMMISSION:
 STANDARD COMMISSION SCHEDULE NON-STANDARD COMMISSION SCHEDULE (PLEASE SPECIFY): _____ %
 NOTE: Employer agrees that this special commission is reflected in the final premium.

PRODUCER AGREES THAT ANY AGENT OF RECORD CHANGE IS SUBJECT TO APPROVAL BY CHSIC AND/OR CHMO AND THAT ANY COMMISSIONS PAYABLE ARE SUBJECT TO CHANGE AT THE DISCRETION OF THE COMPANY. COMMISSIONS ARE PAID TO AGENT OR AGENCY AS DIRECTED IN AGENT/BROKER AGREEMENT.

3 SIGNATURE OF WRITING PRODUCER: _____ PRINTED NAME: _____ DATE SIGNED: _____

SECTION K: TERMS, CONDITIONS, AUTHORIZATIONS, AND OTHER PROVISIONS

Cox Health Systems Insurance Company (CHSIC) and/or Cox Health Systems HMO, Inc. (CHMO) and the Employer/Association (as identified in Section A.) including any affiliated entities named above (the "Group") hereby agree that CHSIC/CHMO shall contract and/or arrange for medical and hospital services in accordance with the terms and provisions of the Evidence of Coverage (EOC), to eligible subscribers of the Group and their eligible dependents who elect to enroll hereunder. This Group Employer Application, the EOC, and any riders thereto, and with respect to the coverage of individual subscribers, the enrollment application of the subscriber, together constitute the entire contract. The Group agrees that the Contract may be amended from time to time by CHSIC/CHMO upon thirty (30) days prior written notice to the Group. Any such amendment will be effective on the date specified by CHSIC/CHMO and will be deemed accepted upon payment of the first premium due after date of the notice, unless otherwise provided in the EOC. No other person other than an authorized representative of CHSIC/CHMO has authority to change, modify, or alter this contract.

Enrollment Period: The initial open enrollment period begins thirty (30) days prior to, and ends on, the Group Contract effective date. Unless a different annual open enrollment period is specifically agreed to by CHSIC/CHMO in this application, the open enrollment period beginning thirty (30) days prior to, and ends on, the Group Contract anniversary date, which is twelve (12) months after the effective date.

SECTION K: TERMS, CONDITIONS, AUTHORIZATIONS, AND OTHER PROVISIONS (Continued)

Enrollment: The Group agrees to offer CHSIC/CHMO membership to all eligible employees of the Group. The Group agrees that after the initial open enrollment period under this contract, each new employee will be given the opportunity to elect CHSIC/CHMO membership as a procedure of employment, and that enrollment in accordance with such election will become effective when such person has fulfilled the waiting period and eligibility requirements as contained in this contract and the EOC.

Pre-Existing Conditions: A pre-existing condition provision may apply to an employee or dependent enrolling in a CHSIC PPO health plan. When it does, pre-existing conditions will not be covered for a period of time where benefits will be limited as described in the EOC, not more than twelve (12) months. The pre-existing conditions provision may be waived if the employee or dependent was covered by a prior qualifying plan in certain situations. These provisions will be described in the Evidence of Coverage issued to the employee and will never be more restrictive than the applicable state law.

Premiums and Payment: Premiums are due the last business day of the month preceding next months' coverage. The initial premium must be paid in advance of the effective date. Thereafter, the Group agrees to remit on or before the premium due date the full monthly amount set forth in the premium schedule for each eligible subscriber and dependent(s) enrolled hereunder, in accordance with CHSIC/CHMO records. CHSIC/CHMO reserves the right to adjust premium rates at renewal and as otherwise set forth in the EOC upon thirty-one (31) days notice to the Group. Adjusted renewal rates will take effect upon the first month of the renewal period and will be deemed accepted upon payment of the first premium due upon renewal. Premiums are not pro-rated for partial month coverage.

TERM and termination: Contract will become effective at 12:01 a.m. Central Time on the effective date specified above, subject to payment of premiums as provided herein, and will remain in force and effect for a period of twelve (12) months. For each twelve (12) month renewal period thereafter, subject to the right of either CHSIC/CHMO or the Group to terminate the contract. The Contract will be terminated without notice as of 12:00 midnight on the last day of the thirty-one (31) day grace period following the premium due date if premiums are not paid on or before the premium due date or during the grace period, unless otherwise agreed upon by CHSIC/CHMO. All statements are considered representations and not warranties. After coverage has been in force for two years, no statement will void the contract or reduce benefits unless the statement was fraudulent and it is contained in a written instrument signed by the person making the statement. In the case of fraud, the Contract may be terminated immediately upon written notice to the Group.

If the Contract is terminated by the group without thirty-one (31) days prior written notice to CHSIC/CHMO, the Group will be liable for premiums and service charges for that billing period or periods for which claims were paid.

COBRA/ERISA: CHSIC and/or CHMO and the Group agree that the Group is the COBRA/ERISA Administrator in connection with this plan, and that the Group is exclusively responsible for complying with all COBRA/ERISA requirements. Group further agrees that it will indemnify and hold CHSIC/CHMO harmless for any damages, attorney's fees, and costs it incurs in connection with any failure on the part of the Group to comply with COBRA or ERISA requirements.

You, the employer, understand and agree that the first month's estimated premium and fully completed enrollment information for all eligible persons must be submitted with this Application BEFORE action is taken on the Application. Insurance coverage is not in effect unless and until you receive written confirmation from us.

UNDER NO CIRCUMSTANCES SHOULD YOU CANCEL YOUR PRESENT GROUP INSURANCE COVERAGE WITHOUT PRIOR WRITTEN NOTICE OF APPROVAL BY AN OFFICER OF CHSIC AND/OR CHMO.

CHSIC/CHMO reserves the right to retain all or part of the initial premium deposit if the group-initiated termination takes place after CHSIC/CHMO has approved coverage for this group.

During and after termination of the Contract, the Group grants CHSIC/CHMO permission to use and/or transfer to third parties for research and analysis purposes the claims and related medical data in CHSIC/CHMO possession. The parties shall maintain the confidentiality of any information related to covered persons in accordance with any applicable laws. Neither party shall disclose any confidential business information of the other party without written consent of that party.

The Group shall notify CHSIC/CHMO promptly of any changes in this information that may affect the eligibility of employees or their dependents, including the addition of any newly eligible employees or dependents. CHSIC/CHMO shall be entitled to rely on the most current information in its possession regarding eligibility of employees and their dependents in providing coverage under the Contract.

No producer, agent, broker, or consultant is authorized to waive a complete answer to any question on the Application, determine membership eligibility, make or alter any contract, or waive any of the rights of CHSIC/CHMO. All contract terms must be in writing and signed or accepted in writing, by an authorized officer of the Group and an authorized office of CHSIC/CHMO to be binding upon either party.

Cox Health Systems Insurance Company and/or Cox Health Systems HMO, Inc. reserves the right to reprice and reissue new premium rates should total enrollment change by more than 10% at any time during the contract year of this plan.

AUTHORIZATION:

I, as an authorized representative of the Group, certify to the best of my knowledge, the information I have furnished is correct. I also understand that CHSIC/CHMO will review this information and reserves the right to amend or withdraw its group insurance proposal based on this information.

Signature of Authorized Officer:

Printed Name of Authorized Officer:

Title:

Date Signed:

SECTION L: OPTIONAL EMPLOYER UNDERWRITING APPLICATION (May be completed by groups of 26-99 eligible employees whom are applying for employer underwriting. If employee health statements will be completed, please omit this section.)

Eligible Groups: Employer groups of 26 - 99 eligible employees.

Pricing: Pricing will be determined by the underwriting based on disclosed health information, rate history, persistency, and other known characteristics of the group (e.g. nature of business, prior history with CHP). The underwriter reserves the right to request additional information, including the necessity of full medical underwriting based on health disclosure on Employee Applications.

Persistency: Groups that have changed carriers in each of the previous two years are ineligible; exceptions may be granted if CHP was the carrier two years previous, at the discretion of the underwriter.

Exclusions: Certain groups may be deemed ineligible for employer underwriting quotation based on underwriter discretion. The following industries are specifically excluded from employer underwriting quotation: • Trucking

Data Requirements: The following information is required to be eligible for quotation:

- Group Contract Health Addendum form
- Accurate census
- Current rates (on current carrier paper)
- Renewal rates (on current carrier paper)
- Detailed benefit description
- Two years of carrier history

HEALTH INFORMATION - To the best of your knowledge, complete for all persons(employees or dependents) to be covered under this policy.

1	Has any person been treated for a serious illness (physical or mental), had more than \$10,000 of medical expenses, been hospitalized for had surgery in the past 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2	Does any person have an existing mental or physical disorder requiring clinical treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3	Has any person been advised in the last 6 months to have surgery, anticipate hospitalization, or significant medical treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4	Are there any persons currently confined to a hospital or treatment facility?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5	Are there any persons currently pregnant or receiving fertility treatments?	Yes	No
6	Are there any persons who are not actively performing normal duties full-time due to illness/injury?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Complete the following for any known medical conditions in your group:

<input type="checkbox"/> AIDS,HIV+ <input type="checkbox"/> Alzheimer's <input type="checkbox"/> Aneurysm, Type: _____ <input type="checkbox"/> Anxiety/Depression <input type="checkbox"/> Back/Spine Injuries, Type: _____ <input type="checkbox"/> Cancer Present (within 1 year) Type: _____ <input type="checkbox"/> Recovered 1-5 yrs. Type: _____ <input type="checkbox"/> Recovered 6-10 yrs. Type: _____ <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Circulatory: <input type="checkbox"/> Coronary Artery Disease (within 3 yrs.) <input type="checkbox"/> Heart Attack, date: _____ _____ Operated / _____ Not Operated <input type="checkbox"/> Chronic Obstructive Pulmonary Disease (COPD)	<input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Diabetes: # cases: ____ Type I ____ Type II <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Hemophilia <input type="checkbox"/> Kidney Dialysis/Renal Failure <input type="checkbox"/> Liver (Cirrhosis) <input type="checkbox"/> Liver (Hepatitis non-alcoholic) <input type="checkbox"/> Lupus/Connective Tissue Disease <input type="checkbox"/> Lyme's/Parasitic Disease <input type="checkbox"/> Lymphoma/Leukemia <input type="checkbox"/> Mental Health Disorder <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Muscular Dystrophy	<input type="checkbox"/> Pancreatitis <input type="checkbox"/> Paralysis <input type="checkbox"/> Pregnancy Due date(s): _____ <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Reproductive Disorders <input type="checkbox"/> Spina Bifida <input type="checkbox"/> Stroke (within 3 yrs.) <input type="checkbox"/> Substance Abuse (within 3 yrs.) <input type="checkbox"/> Transplant Type & Date: _____ <input type="checkbox"/> Other not listed: _____ _____ _____
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HEALTH INFORMATION DETAILS (Please provide full details for any conditions checked or questions answered "Yes" above. Use additional paper if necessary. Please sign and date all pages.)

QUESTION #	DIAGNOSIS/CONDITION	CURRENT STATUS/PROGNOSIS
Name & Title of Authorized Company Representative:		Signature of Authorized Company Representative: Date: