GROUP HEALTH STATEMENT

School District Name:	Email Address:	Phone Number:
Employee Name:	Employee Date of Birth:	Spouse Date of Birth (N/A if not applicable):

Active Employee: YES NO	**Retired Employee:** YES NO
I have Medicare A&B: YES NO	**My spouse has Medicare A&B:** YES NO

Check all Coverage Desired for next year:

Employee Only **Employee/Spouse** **Employee/Children** **Employee/Family** **Waiving Coverage**

Total number to be covered (including self, spouse, and # of children): ____________________

If you plan to request coverage from MUST, please complete the rest of this form. If you plan to waive MUST coverage, you may skip to the "Agreement and Authorization" section on the back of this form. All forms must be signed and dated to be considered valid.

MEDICAL INFORMATION

SECTION A: If you answer yes to this question, please complete Section B below.

Within the last 4 years, have you or any dependent been diagnosed with, received or been recommended to have treatment and/or medication(s) for, consulted a physician or other medical professional or had any test performed for any disorders or conditions of the following? YES NO

Y	N	
		1. Back
		2. Liver
		3. Heart or circulatory (other than high blood pressure)
		4. Stroke
		5. Tumor/cancer
		6. Intestinal/colon
		7. Diabetes
		8. Substance abuse
		9. AIDS, AIDS-related complex

Y	N	
		10. Reproductive organs
		11. Respiratory
		12. Kidney
		13. Arthritis
		14. Muscular
		15. Neurological
		16. Mental or emotional
		17. Seizures
		18. Hemophilia

Y	N	
		19. Other

Did you check YES to any of the above disorders or conditions? YES NO

SECTION B: IMPORTANT! Please provide complete details to all conditions treated in the last 4 years. Include names, dates, diagnosis, and treatment and/or medication(s). Please indicate if complete recovery.

Condition Number	Relationship of Person Treated, Date of Birth and Gender	Nature of Condition; and/or Diagnosis	Duration Dates		Explain Treatment: Include Date of Disability, Hospitalization, Medication (include dosage), Tests and Surgery	Results or Degree of Recovery
			From	To		

See the back of the page!

Condition Number	Relationship of Person Treated, Date of Birth and Gender	Nature of Condition; and/or Diagnosis	Duration Dates		Explain Treatment: Include Date of Disability, Hospitalization, Medication (include dosage), Tests and Surgery	Results or Degree of Recovery
			From	To		

PLEASE STOP AND REVIEW THIS APPLICATION. If you answered Yes or checked any box in Section A, you must provide details as requested in Section B.

AGREEMENT AND AUTHORIZATION

I have read the questions and answers on this application and acknowledge that the answers are complete and true to the best of my knowledge and belief.

I understand that all information on this form is Protected Health Information and will only be sent to the MUST underwriters to establish a new business premium quote and **will not** be shared with my employer. I authorize the MUST underwriters to use the information on this form to evaluate my application.

I also understand that failure to complete and sign this Authorization will result in my application not being considered. I agree this Authorization will be valid until MUST has completed its determination of my eligibility for coverage. A simulated, faxed or copied image of this Authorization shall be as valid as the original. I (or my authorized representative) may obtain a copy of this form upon request.

I acknowledge that by typing my name below it is the legal equivalent of my manual signature on this form. I certify that the information on this form is true and accurate.

EMPLOYEE SIGNATURE:_______________________________________ **DATE:**____________________________