

**OREGON STANDARD HEALTH STATEMENT**  
(Standard Form per ORS 743.766)

**PART A:**

(Insert carrier's logo/information here; format may vary, but may not include questions relating to health-risk status, such as occupation, hobbies, etc.)

Name: \_\_\_\_\_

Residence address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ County: \_\_\_\_\_

Billing address (If different from residence address):

\_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Do you or any family members have other active health or medical coverage, Medicare, Medicare Advantage or Medicare supplement coverage?  Yes  No

If yes, name of insurance company: \_\_\_\_\_

Effective date of current medical coverage: \_\_\_\_\_

Termination date of current medical coverage: \_\_\_\_\_

Do you or any family member work for an employer who offers health benefits to employees?

Yes  No

Are you or any family members enrolled?  Yes  No

If no, why? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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**PART B:** (Cannot include other health questions or questions relating to health-risk status, such as occupation, hobbies, etc., and cannot include questions concerning genetic testing of or genetic information about the applicant or any blood relative of the applicant.)

**NOTICE TO APPLICANT:** You are not required to disclose any information on any part of this application about genetic testing or genetic information relating to you or to any blood relative. You are not required to disclose any decision by an insurance company that is based on a genetic test or on genetic information.

Has any insurance company within the last five years declined, postponed, refused, restricted or increased premium for health reasons for life or health insurance coverage for you or any of your family members to be covered?

Yes  No

If yes, name of person affected, reason for action, and name of insurance company:

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**Please provide the following information for each person to be covered:**

	Last name of family member	First name, middle initial	Height	Weight	Sex	Date of Birth	Social Security Number
Subscriber							
Spouse							
Child							
Child							
Child							
Child							
Child							
Child							

Explain the relationship to the subscriber for any person listed above whose last name is different from the subscriber's: \_\_\_\_\_

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Please mark "Yes" or "No" for each item (for you and any family members requesting coverage). Provide details on Page 6 to any questions answered "Yes." (**For the purpose of these questions, chronic means persistent, continuous, or periodic, or a combination of any of these terms.**)

Within the last five years, has **anyone** listed on this application had any medical advice, diagnosis, care, or treatment, including prescribed medications, recommended or received from a licensed health care professional or had any illness, ailment, injury, health problem, symptoms, physical impairment, surgery or hospital confinement related to any of the following conditions:

- |   |  |   |  |
|---|--|---|--|
| 1. AIDS, ARC, HIV positive  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 26. High cholesterol (if "Yes," record last reading on page 6)                              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Alcohol/chemical/drug abuse/habit                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 27. High blood pressure (if "Yes," record last reading on page 6)                           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Anemia/chronic fatigue   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 28. Kidney/kidney stones  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Appendicitis/chronic abdominal pain                                | <input type="checkbox"/> Yes <input type="checkbox"/> No | 29. Knee/shoulder/hip/other joints  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Back/neck/spine  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 30. Liver condition/hepatitis   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Birth defect/congenital deformities                                | <input type="checkbox"/> Yes <input type="checkbox"/> No | 31. Lupus, chronic muscle pain, muscle injury or disease, or fibromyalgia                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Bladder/urinary tract  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 32. a. Mental/emotional condition/depression  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Blood/circulatory  | <input type="checkbox"/> Yes <input type="checkbox"/> No | b. Therapy/counseling within last 5 years (if "Yes," record date of last session on page 6) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Bone/orthopedic  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 33. Neurological condition/disease/injury   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Brain disease or injury/concussion                                | <input type="checkbox"/> Yes <input type="checkbox"/> No | 34. Phlebitis/blood clot  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Breast (lumps or masses)  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 35. Osteoarthritis/osteoporosis/osteopenia  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12. Cancer  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 36. Prostate/elevated PSA/prostatitis   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 13. Chemotherapy/radiation treatment                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 37. Reproductive system disorder/infertility  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 14. a. Colon/rectum/intestine/bowel                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 38. Chronic respiratory/lung condition  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. Blood in stool   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 39. Rheumatoid arthritis  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 15. Convulsion/seizures/epilepsy                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | 40. Sexually transmitted disease(s)   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 16. Diabetes/sugar in urine   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 41. Skin condition, abnormal or cancerous moles or eczema/cysts/cancer                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 17. Chronic ear/nose/throat/tonsil condition/disease/disorder         | <input type="checkbox"/> Yes <input type="checkbox"/> No | 42. Sleep apnea/chronic sleep disorder  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 18. Eating disorders such as, but not limited to, anorexia or bulimia | <input type="checkbox"/> Yes <input type="checkbox"/> No | 43. Stomach disorders/ulcer/acid reflux   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 19. Emphysema/asthma/ chronic lung disease (COPD)                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | 44. Stroke/paralysis/seizures   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 20. Endocrine/gland/hormone system                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | 45. Tumors  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 21. Disease or injury of eye/ cataract/glaucoma                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | 46. TMJ/jaw joint   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 22. Gallbladder/pancreatic disease                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | 47. Weight fluctuation (+/-20 lbs.)   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 23. Chronic headaches/migraines                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | 48. Cosmetic surgery/implants, use of prosthetic devices/limbs                              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 24. Heart/chest pain/angina   | <input type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
| 25. Hernia  | <input type="checkbox"/> Yes <input type="checkbox"/> No |   |  |

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49. Has any person on this application used tobacco products in any form within the last 5 years?

Yes  No. If yes:

Name \_\_\_\_\_ type of product \_\_\_\_\_

Name \_\_\_\_\_ type of product \_\_\_\_\_

Name \_\_\_\_\_ type of product \_\_\_\_\_

50. Please provide the following information for each **female** on this application:

Family member	Name:	Name:	Name:	Name:
a. Initial menstrual cycle begun?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Date of last menstrual period.				
c. If (b) is more than 35 days ago, please explain:				
d. Excessive or absent menstrual bleeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. If (d) is yes, please explain:				
Date of last DEPO Provera shot?				
Abnormal Pap smears?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Prior Cesarean section or miscarriage?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

51. Is any person on this application now pregnant?  Yes  No

If yes, name \_\_\_\_\_ due date \_\_\_\_/\_\_\_\_/\_\_\_\_.

52. Is any person on this application, including male applicants and dependent males or females, responsible for a current pregnancy?  Yes  No

If yes, name \_\_\_\_\_ due date \_\_\_\_/\_\_\_\_/\_\_\_\_.

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53. Please provide the following information for each person on this application. Within the last five years, has any person on this application:

- a. Had any medical advice, diagnosis, care, or treatment, including prescribed medications, recommended or received from a licensed health care professional, or had any illness, ailment, injury, health problem, symptoms, physical impairment, surgery or hospital confinement not listed above?     Yes  No
- b. Had chronic cough, fatigue, diarrhea, or enlarged glands?     Yes  No
- c. Been advised to have or contemplated having an operation or medical procedure not yet performed?     Yes  No
- d. Been scheduled to see a health care provider?     Yes  No
- e. Taken any prescription medication on a regular basis?     Yes  No

54. List all medications currently being taken by any person on this application:

Name	Medications	Prescribed by (name/address/telephone)	Date prescribed



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Be sure to sign and date the application. Spouse's signature is required if married. Signature applies to both "Certificate of Completeness and Correctness" and "Authorization for Release of Information."

**CERTIFICATION OF COMPLETION AND CORRECTNESS**

I affirm that the answers given in this "Oregon Standard Health Statement" are complete and correct. I have provided these answers as part of the application procedure required by this insurance carrier to enroll in its insurance coverage. I understand that if this application contains any material misstatements or omissions, the insurance carrier may, within the first two years of coverage, deny coverage, modify or cancel the contract, or take other legal action. I will promptly inform the insurance carrier in writing if anything happens before my coverage takes effect that makes this incomplete or incorrect. I understand and agree that no coverage shall be in force until approved by the insurance carrier. If approved, coverage will be in force as of the effective date determined by the carrier. The carrier may contact me to clarify answers on this application. As the applicant, I understand I have the right to inspect the information in my file.

\_\_\_\_\_  
(Signature of applicant or applicant's representative)

\_\_\_\_\_  
(Signature of spouse or spouse's representative, if applicable)

**CONDITIONAL AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION**

**NOTE:** An insurer shall insert here and use the conditional authorization statement, along with signature lines, that the insurer normally uses to comply with the federal Health Insurance Portability and Accountability Act of 1996 (P.L.104-191) (HIPAA). An insurer may also include a conditional authorization signature provision that allows a parent to sign for a dependent older than 18 when that action is allowed under HIPAA.

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