South Carolina

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BLUE MEASURE HEALTH STATEMENT

Product Selected (if offered more than one)

Choose an item

Must Select Employer Sponsored Plan

Name: _____ Employee Social Security #: __ __ __ - __ __ - __ __ __ __

Name of Employer: _____

Employee: Height: _____ ft. _____ in. / Weight: _____ lbs. Spouse: Height: _____ ft. _____ in. / Weight _____ lbs.
(if coverage is to include spouse)

The following questions apply to **ALL** persons, including dependents, applying for coverage. Please provide details of any "yes" answers in the space provided or in an attached and signed document. In the past three (3) years, have you or any persons listed on the application been diagnosed, treated or advised to seek treatment or testing, or had symptoms related to any of the following:

1. Blood Disorders/ Circulatory System ☐ Yes ☐ No

☐ Anemia ☐ Aneurysm ☐ Angina/Chest Pain ☐ Angioplasty/By-Pass ☐ Blood Clot ☐ Carotid Artery Disease
☐ Congestive Heart Disease ☐ Coronary Artery Disease ☐ Elevated Cholesterol/Triglycerides ☐ Heart Attack ☐ Heart Murmur
☐ Hemophilia ☐ Irregular Heartbeat ☐ Phlebitis ☐ Polycythemia Vera ☐ Sickle Cell ☐ Stroke ☐ Varicose Veins
☐ High Blood Pressure (Last three readings/date (Ex. 120 / 80 03 / 13 / 04))
1. _____ ____/____/____ 2. _____ ____/____/____ 3. _____ ____/____/____
Other (specify)_____
Patient's Name_____
Diagnosis/Treatment/Medication_____
Current Status _____ Date Diagnosed _____
Date of Last Doctor Visit_____ Doctor's Name/Phone_____

2. Bones/Injuries/ Muscles and Tissues ☐ Yes ☐ No

☐ Rheumatoid Arthritis ☐ Arthritis (Other) ☐ Broken/Fractured Bones ☐ Bulging/Herniated Disc ☐ Fibromyalgia
☐ Lupus ☐ Necrosis ☐ Back/Neck Disorder (specify)_____ ☐ Other (specify)_____
Patient's Name_____
Diagnosis/Treatment/Medication_____
Current Status _____ Date Diagnosed _____
Date of Last Doctor Visit_____ Doctor's Name/Phone_____

3. Congenital Anomalies/ Birth Defects ☐ Yes ☐ No

☐ Cleft Lip ☐ Cleft Palate ☐ Polycystic Kidney ☐ Spina Bifida ☐ Other (specify)_____
Patient's Name_____
Diagnosis/Treatment/Medication_____
Current Status _____ Date Diagnosed _____
Date of Last Doctor Visit_____ Doctor's Name/Phone_____

4. Digestive System ☐ Yes ☐ No

☐ Cirrhosis of Liver ☐ Hepatitis (specify type)_____ ☐ Other Liver Disorder (specify)_____
☐ Crohn's/Ulcerative Colitis ☐ Colon Disorders (specify)_____ ☐ Gallbladder
☐ Hernia (specify type)_____ ☐ Pancreatitis ☐ Reflux ☐ Ulcer (specify)_____ ☐ Other (specify)_____
Patient's Name_____
Diagnosis/Treatment/Medication_____
Current Status _____ Date Diagnosed _____
Date of Last Doctor Visit_____ Doctor's Name/Phone_____

5. Endocrine System ☐ Yes ☐ No

☐ Diabetes: Oral Medication_____ Dosage_____
Daily Insulin Dosage AM Units_____ PM Units_____
Last three Blood Sugar Readings (Ex. 140 03 / 13 / 04)
1. _____ ____/____/____ 2. _____ ____/____/____ 3. _____ ____/____/____
☐ Cystic Fibrosis ☐ Goiter ☐ Gout ☐ Pituitary Dwarfism ☐ Thyroid ☐ Other (specify)_____
Patient's Name_____
Diagnosis/Treatment/Medication_____
Current Status _____ Date Diagnosed _____
Date of Last Doctor Visit_____ Doctor's Name/Phone_____

6. Infectious/Parasitic Conditions ☐ Yes ☐ No

☐ HIV/AIDS ☐ Sarcoidosis ☐ Tuberculosis ☐ Other (specify)_____
Patient's Name_____
Diagnosis/Treatment/Medication_____
Current Status _____ Date Diagnosed _____
Date of Last Doctor Visit_____ Doctor's Name/Phone_____

7. Mental Health Conditions/Substance Abuse ☐ Yes ☐ No

☐ Alcohol Abuse ☐ Anxiety/Depression ☐ Bipolar ☐ Drug Abuse ☐ Anorexia ☐ Bulimia
☐ Other (specify) _____
Patient's Name_____
Diagnosis/Treatment/Medication_____
Current Status _____ Date Diagnosed _____
Date of Last Doctor Visit_____ Doctor's Name/Phone_____

(continued on back)

8. Nervous System/ Sense Organs
☐ Yes ☐ No

☐ Alzheimer's Disease ☐ Cataract ☐ Cerebral Palsy ☐ Deviated Nasal Septum ☐ Chronic Ear Infection
☐ Epilepsy/Seizures ☐ Glaucoma ☐ Headaches/Migraines ☐ Multiple Sclerosis ☐ Muscular Dystrophy
☐ Paralysis ☐ Parkinson's Disease ☐ Other (specify)_____
Patient's Name_____
Diagnosis/Treatment/Medication_____
Current Status _____ Date Diagnosed _____
Date of Last Doctor Visit_____ Doctor's Name/Phone_____

9. Reproductive System/ Urinary System
☐ Yes ☐ No

☐ Abnormal Pap Smear (Last three Pap Readings (Ex. normal 03 / 13 / 04))
1. _____ ____/____/____ 2. _____ ____/____/____ 3. _____ ____/____/____
☐ Bladder Disorder (specify) _____ ☐ Breast Disorder (specify) _____
☐ Endometriosis/Adhesions ☐ Infertility ☐ Kidney Stones ☐ Kidney Disorder (specify)_____
☐ Pregnant (due date ____/____/____) ☐ Current Pregnancy Complications
☐ Prostate Disorder (specify)_____ ☐ Other (specify)_____
Patient's Name_____
Diagnosis/Treatment/Medication_____
Current Status _____ Date Diagnosed _____
Date of Last Doctor Visit_____ Doctor's Name/Phone_____

10. Respiratory System
☐ Yes ☐ No

☐ Allergies ☐ Asthma ☐ Chronic Sinusitis ☐ Emphysema ☐ Chronic Bronchitis ☐ Pneumonia
☐ Shortness of Breath ☐ Sleep Apnea ☐ Other (specify) _____
Patient's Name_____
Diagnosis/Treatment/Medication_____
Current Status _____ Date Diagnosed _____
Date of Last Doctor Visit_____ Doctor's Name/Phone_____

11. Transplant
☐ Yes ☐ No

☐ Organ (type(s)) _____ ☐ Bone Marrow
Surgery Advised or Pending ☐ Yes ☐ No Surgery Completed ☐ Yes ☐ No Date Completed_____
Other (specify)_____
Patient's Name_____
Diagnosis/Treatment/Medication_____
Current Status _____ Date Diagnosed _____
Date of Last Doctor Visit_____ Doctor's Name/Phone_____

12. Tumor/Cancer/Polyps/ Cyst
☐ Yes ☐ No

☐ Brain ☐ Breast ☐ Colon ☐ Hodgkin's Disease ☐ Leukemia/Lymphoma ☐ Lung ☐ Melanoma
☐ Pancreatic ☐ Polyps (specify type)_____ ☐ Prostate ☐ Sarcoma ☐ Testicular ☐ Other (specify)_____
Patient Name's_____ Date Diagnosed _____
Stage/Level _____ ☐ Malignant ☐ Benign
Diagnosis/Treatment/Medication_____
Current Status _____ Date Diagnosed _____
Date of Last Doctor Visit_____ Doctor's Name/Phone_____

13. Symptoms, Conditions or Treatment not listed above
☐ Yes ☐ No

☐ Abnormal Lab, Test or Physical Exam Results ☐ Pain, Discomfort or Abnormality Not Yet Seen by a Physician
☐ Treatment or Surgery Advised But Not Yet Done Condition_____
Patient's Name_____
Diagnosis/Treatment/Medication_____
Current Status _____ Date Diagnosed _____
Date of Last Doctor Visit_____ Doctor's Name/Phone_____

14. Current Medication
☐ Yes ☐ No

Medication _____	Medication _____	Medication _____
Patient's Name _____	Patient's Name _____	Patient's Name _____
Diagnosis _____	Diagnosis _____	Diagnosis _____

I hereby agree that the answer to each of the above questions is complete and true, that such answers have been fully and correctly recorded, and that no material information concerning the person's past or present health has been omitted. I agree that such answers will form part of my application for coverage under my Group Health Plan.

PRINT NAME_____

SIGNATURE_____ DATE_____