



PERSONAL HEALTH STATEMENT

Employees must complete this form if they have requested insurance coverage for themselves or any of their family members and are required to show evidence of good health.

For questions about how to complete this form, call United Heritage Life Insurance Company at

1-800-657-6351

Upon Completion:

Send both the Employer and Employee sections of this form to:

United Heritage Life Insurance Company

Group Department

P.O. Box 7777

Meridian, Idaho 83680-7777

**Please remember your form can not be processed without your signature and current date.
Please keep a copy of the completed forms for your records**

Instructions

Employer's Responsibility

1. Fill out the Employer Section completely. Please note an incomplete form will result in further correspondence that will delay the final time to decision. (Refer to your Policy Contract and employee records.)
2. In Section #1 "Who Requires a Personal Health Statement?" indicate with a check mark all who are required to provide evidence of good health – employee, spouse or child– and for each, check the reason(s) why. Refer to your Policy Contract for coverage amounts, eligibility periods (for late entrant determination) and guarantee issue limits.
3. In Section #2 "Coverage Summary," complete all coverage amounts for each Enrollee. **Basic Life Coverage amounts are important and must be included for all Enrollees requesting additional Life coverage.** Refer to your policy contract and employee records to determine current coverage amounts, if any.
4. After completing the Employer section, forward the entire form, including both the Employer and Employee Sections, to the employee to complete.
5. No premiums should be deducted on additional amounts applied for until a final decision regarding coverage is received from United Heritage Life Insurance Company's Group Underwriting Department.

Employee's Responsibility

1. Make sure your Employer has already completed the Employer Section of this form in full.
2. The Employer Section clarifies which Enrollees need to show evidence of good health and be listed on this Personal Health Statement. Refer to EMPLOYER SECTION 1 of the form where a box has been marked for each person who is required to fill out a Personal Health Statement – you (the employee), your spouse or child. Enter the names of these individuals on the Personal Health Statement under EMPLOYEE SECTION 1 "Enrollees Requiring Health Evaluation," and fill in the information requested.
3. Answer all questions completely and accurately. Even minor details like height and weight are very important and must be accurate.
4. An enrollee will be responsible to pay for the cost of physical exams, medical tests or medical records retrieval if they are required now or are requested during the underwriting process.
5. **YOU, THE EMPLOYEE MUST SIGN THIS FORM IN BOTH AREAS INDICATED** (even if you yourself are not applying for coverage). Use your full legal signature, and enter the date signed. Your spouse must sign this form **ONLY** if using this form to apply for coverage. He or she must use a full legal signature, and enter the date signed.
6. **BOTH THE EMPLOYER AND EMPLOYEE SECTIONS OF THIS FORM MUST BE COMPLETED AND RECEIVED BY UNITED HERITAGE WITHIN 30 DAYS OF THE SIGNATURE DATE.**
7. The medical and personal information you complete on this form will be considered "current" up to 90 days from the date this form is signed. Leaving information blank can result in delays or may result in your file being closed.

EMPLOYEE SECTION

Personal Health Statement

BEFORE MAILING

Please print in dark ink. Initial any changes

Employee First Name:	MI:	Last Name:
Mailing Address:		
City:	ST:	ZIP:
Social Security Number:	Occupation:	
Can we call you for any additional or missing information?: YES: <input type="checkbox"/> NO: <input type="checkbox"/>	Work Phone: ()	
E-Mail:	Home Phone: ()	

• Answer all the questions and **DATE and SIGN** this form in both areas indicated.
 • Keep a copy for your records. **Mail the completed Employer and Employee section to:**
 United Heritage Life Ins. Co.
 Group Department
 P.O. Box 7777
 Meridian, Idaho 83680-7777

EMPLOYEE SECTION 1: Enrollees Requiring Health Evaluation (This is critical information and if left blank further correspondence will be generated)

List below the names of Enrollees identified in Employer Section I.

First Name, MI, Last Name	ENROLLEES	HEIGHT (ft/in) Required	WEIGHT (lbs) Required	DATE OF BIRTH Required	GENDER
_____	Employee	_____	_____	___ - ___ - ___	M F
_____	Spouse	_____	_____	___ - ___ - ___	M F
_____	Child	_____	_____	___ - ___ - ___	M F
_____	(all eligible children must be listed)	_____	_____	___ - ___ - ___	M F
_____		_____	_____	___ - ___ - ___	M F

EMPLOYEE SECTION 2: Health Questions

Questions 1-11 are to be answered by all Enrollees listed above. **For all "Yes" answers; provide additional details in the sections provided.**

During the past 10 years have you or any of your dependents: YES NO

1. Had or been told to have surgery, been hospitalized, filed for Worker's Compensation, been declined for life, health or disability insurance, or consulted or been examined by any healthcare provider for anything other than normal physical exams or acute illnesses such as cold, flu or sore throat?

During the past 10 years have you or any of your dependents been diagnosed as having or been treated for: (Applies to questions 2-7 only)

2. Heart disease, stroke, circulatory problems, diabetes, cancer, tumor, or any congenital, digestive, liver, thyroid, kidney, bladder or urinary tract disease or disorder?
3. Asthma, bronchitis, emphysema, allergies, pneumonia or other respiratory condition or disorder?
4. Brain or nervous system problems, epilepsy, depression or any other psychiatric, mental or nervous disorder?
5. Arthritis, rheumatism, back, spine or any other skeletal or muscular disease or disorder?
6. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for antibodies to the AIDS virus?
7. Alcohol or substance abuse or been advised to limit or cease consumption of or seek treatment for the use of alcohol and drugs?

Currently are you or any of your dependents: (Applies to questions 8-11 only)

8. Pregnant?
9. Taking medication for any condition or disease?
10. Have you or your dependents experienced enlarged lymph nodes or unexplained weight loss?
11. Have you or your dependents had any injury, birth defect, congenital defect, disease or other disorder not mentioned above?

Furnish details here for any "Yes" answers on question 1 through 11: (Use a separate sheet if more room is required.)

Question Number			
Name of Enrollee			
Medical Condition			
Date Treatment Started			
Duration			
Current Status			
Treatment/Medication			
Names and Addresses of Physicians Consulted			

Furnish details here for any "Yes" answers on question 1 through 11: *(Use a separate sheet if more room is required.)*

Question Number			
Name of Enrollee			
Medical Condition			
Date Treatment Started			
Duration			
Current Status			
Treatment/Medication			
Names and Addresses of Physicians Consulted			

Notice: Enrollee is required to notify United Heritage Life Insurance Company in writing of any changes in any enrollee's medical condition between the date that enrollee signs this form and the date coverage is approved.

I hereby certify that the above statements and answers are complete and true to be the best of my knowledge and belief concerning the past and present state of health and medical history of the persons to whom the statements and answers relate. I agree that this document and all its contents shall form a part of my enrollment request for group benefits.

For your protection please be aware any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to civil fines and criminal penalties. This information may be used by the United Heritage Life Insurance Company to decide if the person(s) is/are eligible for coverage.

EMPLOYEE'S SIGNATURE (required)

____ - ____ - ____
DATE SIGNED

SPOUSE'S SIGNATURE
(required only if applying for coverage)

____ - ____ - ____
DATE SIGNED

EMPLOYEE SECTION 3: Enrollee Authorization

Employee Name – First Name

MI

Last Name

SSN

**Authorization to Disclose Protected Health Information
To Be Used To Determine Eligibility for Group Life and/or Disability Income Coverage**

I have requested insurance coverage under a Group Life and/or Disability Income Policy issued by United Heritage Life Insurance Company (UHLIC). To properly assess my eligibility for this coverage, UHLIC may require that I authorize disclosure of a copy of my entire medical file to them. This authorization is consistent with the requirements under §164.508(c) of the Standards for the Privacy of Individually Identifiable Health Information under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), effective April 14, 2003.

I **authorize** any physician, medical or health practitioner, counselor, therapist, hospital, clinic, or other medical or medically-related facility, insurance or reinsurance company, the Medical Information Bureau, Inc., consumer reporting agency or employer that has records or knowledge of me, or my health, or my children, or their health, to disclose to the UHLIC or its representatives, any non-medical information or medical information, including but not limited to x-rays, photocopies of medical records, medical histories, physical, mental or diagnostic examinations and treatment notes, that relates to: 1) Pre-existing or current illnesses, sicknesses, disease, disabilities, disorders, accidents, injuries or any other health conditions; 2) Confinements in hospitals, medical facilities or medical clinics; 3) Outpatient treatment in hospitals, hospital emergency rooms, medical facilities or clinics, or by medical doctors or other health practitioners; 4) Drug abuse, alcohol abuse, or mental health information protected by Federal Law; 5) Counseling or therapy. (All of the foregoing information is called “health information” in the following sections.) **UHLIC will use this information to assess my eligibility and/or claim for insurance or benefits coverage under an existing Group Life and/or Disability Income policy.**

By signing this form I acknowledge that I **understand** the following:

- That any health information used or disclosed in accordance with this authorization may be subject to re-disclosure by the recipient and no longer subject to the privacy protections of HIPAA.
- That my request for coverage may be delayed and/or denied if UHLIC is unable to obtain health information necessary to properly assess its underwriting risk because I do not properly sign, date, and deliver this authorization or any person subject to HIPAA that receives it does not comply with it.
- That if UHLIC denies my request for coverage and this denial is based, in whole or in part, on health information obtained in connection with this authorization, UHLIC will not release this information to me unless otherwise authorized by the person or entity, including my physician or other medical professionals, that disclosed such information to UHLIC unless required by law.
- That, if necessary, UHLIC will send this authorization to persons or entities listed on my Personal Health Statement to receive health information about me. UHLIC will also provide me with written notice of the persons or entities to which UHLIC sends my authorization. I have a right, at any time, to revoke this authorization by submitting a written request directly to such persons or entities. My revocation will not be effective to the extent that action has been taken in reliance upon this authorization or the authorization was granted as a condition for obtaining insurance coverage and UHLIC otherwise has the right to contest the policy or claim under the policy.
- That this authorization will expire two (2) years from the effective date of my coverage or if no coverage has been issued, one (1) year from the date of this application.
- That a photographic copy of this authorization shall be as valid as the original.
- That I am entitled to a signed copy of this authorization.

EMPLOYEE’ S SIGNATURE
(required)

SPOUSE’ S SIGNATURE
(required only if applying for coverage)

____ - ____ - ____
DATE SIGNED

____ - ____ - ____
DATE SIGNED

This section is very important. Your form cannot be processed without it.

Questions? Call 1-800-657-6351