



MEMBER ID: \_\_\_\_\_

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## INSTRUCTIONS FOR COMPLETING A STATEMENT OF HEALTH FORM

A separate Statement of Health form is required for each applicant applying for benefits beyond initial 90-days of eligibility. Refer to Plan Highlights Booklet for eligibility details.

A completed UCC Medical and Dental Benefits Enrollment Application must accompany this completed form.

### Information to be completed by the applicant:

- Complete employee name and Social Security number.
- Include employee address, telephone number, and e-mail address.
- Include relationship of applicant to employee:
  - Applicant Name
  - Gender
  - Date of Birth
- **Medical Information must be completed in full.**
  - Complete Question 1 with height/weight information.
  - Check "Yes" or "No" for Questions 2-6.
    - Complete the DETAILS SECTION on page 2, if you have listed any medications under Question 2, or if you have answered "Yes" to any Questions 3-6.
  - Complete Question 7.  
*(Provide personal physician contact information and date/reason for last visit.)*
- **Sign the Declaration on page 3.**
  - Any dependent age 18 or older requesting insurance must sign and date his/her form. For dependents under the age of 18, the employee must sign the form.
- **Sign the Authorization Agreement on page 4.**
  - Any dependent age 18 or older requesting insurance, must sign and date his/her form. For dependents under the age of 18, the employee must sign the form.

**Any incomplete or unsigned Statement of Health Form will be returned and not accepted by the Pension Boards. This could cause a delay in the underwriting review process.**

Please send the completed forms by either email or fax to: "ATTN: Health Plan Services."

- Email: [info@pbucc.org](mailto:info@pbucc.org); or
- Fax to: 212.729.2701

*Please print and keep a copy for your records.*

## STATEMENT OF HEALTH FORM FOR MEDICAL COVERAGE

This form is to be completed by the individual requesting health coverage. A separate form must be completed for each applicant.

Name of Employee : \_\_\_\_\_ Employee SSN: \_\_\_\_\_

Relation to Applicant:

- Self  
 Spouse or Partner  
 Dependent

Name of Applicant (last, first, middle initial): \_\_\_\_\_ Title: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender:  M  F Status: \_\_\_\_\_

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

Cell Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Email: \_\_\_\_\_

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### MEDICAL INFORMATION

Omitted information will cause delays. "You" and "Your" refers to the applicant.

1. Height (feet/inches): \_\_\_\_\_ Weight (pounds): \_\_\_\_\_

Complete the **DETAILS SECTION** below for any medications listed or any "Yes" answers to questions 2-6.

2. Are you currently:

Y  N a) Taking any prescribed medication or are on a prescribed diet?  
If yes, please list: \_\_\_\_\_

Y  N b) Receiving or applying for any disability benefits, including workers' compensation?  
If yes, please list the medical condition(s): \_\_\_\_\_

3.  Y  N In the past five years, have you received medical treatment or counseling by a physician, or been advised by a physician to discontinue the use of alcohol, prescribed drugs, or non-prescribed drugs?

4.  Y  N Do you use tobacco products? (including cigarettes, cigar, pipe, or chewing tobacco)

5. Have you ever been diagnosed, treated, tested, or been given medical advice by a physician or other health care provider for the following conditions:

- Y  N a) Chest pain or heart disease or condition?  
 Y  N b) High blood pressure, stroke, or circulatory disorder?  
 Y  N c) Cancer or tumors?  
 Y  N d) Anemia, leukemia, or other blood disorder?  
 Y  N e) Diabetes or disorder of the pancreas?  
If yes, is the condition insulin-treated?  Y  N  
 Y  N f) Ulcers, stomach, or liver disorder?  
 Y  N g) Asthma, bronchitis, emphysema, tuberculosis, pneumonia, or other lung/respiratory disease?  
 Y  N h) Colitis, Crohn's, or any intestinal disorder?  
 Y  N i) Epilepsy, paralysis, dizziness, or neuromuscular disease?  
 Y  N j) Mental illness or nervous disorder?  
 Y  N k) Lyme disease, Epstein-Barr, or chronic fatigue syndrome?

- Y  N    l) Arthritis, lupus, carpal tunnel, or any muscle weakness or connective tissue disease?
- Y  N    m) Kidney or urinary tract disorder?
- Y  N    n) Thyroid or other gland disorder?
- Y  N    o) Back, neck or spinal disorder?

6. Have you ever been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS); AIDS Related Complex (ARC); or HIV-related or other immune system deficiency disorders?  
 Y  N

7. Name of Personal Physician: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Date/Reason for Last Visit: \_\_\_\_\_

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

**DETAILS SECTION**

Provide details for any medications listed or any "Yes" answers to questions 2-6.

Question Number	Diagnosis / Condition	Date(s) of Onset & Treatment	Details of Symptoms and Treatment Received	Name of treating physician, clinic, or hospital (include phone number and complete address)

**DECLARATION**

[ ] I have read this Statement of Health and declare that all information given above is true and complete to the best of my knowledge and belief. I understand that this information will be used by the UCC Health Benefits Plan to determine my insurability.

**Fraud Warning:**

If you reside in or are applying for insurance under a policy issued in one of the following states, please read the applicable warning:

**New York** (only applies to Accident and Health Benefits (AD&D/Disability/Dental): Any person who knowingly and with intent to defraud any Insurance company or other person files an application for insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**Florida:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Massachusetts:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, and may subject such person to criminal and civil penalties.

**New Jersey:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**Oklahoma:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

**Kansas and Oregon:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of insurance fraud, and may subject such person to criminal and civil penalties.

**Virginia:** Any person, who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement may have violated state law.

**In any other case, read the following warning:**

Any person who knowingly and with intent to defraud any insurance company or other person who files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Employee Signature \_\_\_\_\_ Date: \_\_\_\_\_

Applicant Signature \_\_\_\_\_ Date: \_\_\_\_\_  
*(Applicant signature is not required for applicants under the age of 18)*

## AUTHORIZATION

In connection with an enrollment for group medical benefits, for underwriting and claim purposes regarding the proposed beneficiaries (the beneficiaries are the "employee", spouse, and any other person(s) named below), notwithstanding any prior restriction placed on information, records or data by the proposed participant authorizes:

- Any medical practitioner, facility, or related entity; any insurer; any employer; any group policy holder; contract holder or benefit plan administrator; or any government agency to give Mountain State Blue Cross Blue Shield:
  - personal information and data about the proposed participant;
  - medical information, records, and data about the proposed participant including information, records and data about drugs prescribed, medical test results and sexually transmitted diseases.
  - information, records and data about the proposed participant related to alcohol and drug abuse and treatment, including information and data records, and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2, will only be disclosed as permitted by applicable law;
  - information, records, and data about the proposed participant relating to Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related conditions including, where permitted by applicable law, Human Immune deficiency Virus (HIV) test results; and
  - information, records, and data about the proposed participant relating to mental illness, except psychotherapy notes.

### Expiration, Revocation and Refusal to Sign

This authorization will expire 24 months from the date on this form or sooner if prescribed by law. Unless permitted by applicable law, the proposed participant cannot revoke this authorization: (1) to extent that Mountain State Blue Cross Blue Shield has taken action relying on the authorization; or (2) if Mountain State Blue Cross Blue Shield obtained the authorization as a condition to the proposed participant obtaining coverage. In all other cases, the proposed participant may revoke this authorization at any time. To revoke the authorization, the proposed participant must write to Mountain State Blue Cross Blue Shield and inform Mountain State Blue Cross Blue Shield that this authorization is revoked. Any action taken before Mountain State Blue Cross Blue Shield receives the proposed participant's revocation will be valid. Revocation may be the basis for denying coverage or benefits. If the proposed participant does not sign this authorization, that person's enrollment for group medical benefits cannot be processed.

### By signing below, each proposed participant acknowledges his or her understanding that:

- Medical information, records and data that may have been subject to federal and state laws or regulations, including federal rules issued by Health and Human Services, setting forth standards for the use, maintenance and disclosure of such information by health care providers and health plans and records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- Information obtained pursuant to this authorization about the proposed participant may be used, to the extent of applicable law, to determine the insurability of other family members.
- Each proposed participant has a right to receive a copy of this form.

**A photocopy of this form is as valid as the original form.**

Applicant Signature, or Signature and Relationship of Representative: \_\_\_\_\_

Print Applicant Name: \_\_\_\_\_ Date: \_\_\_\_\_

If a child proposed for benefits is over 18, they must sign this authorization. If under 18, a Personal Representative must sign and indicate the legal relationship between the representative and the proposed participant.

## HOW WE USE AND DISCLOSE WHAT WE KNOW ABOUT YOU

We may use what we know about you to help us serve you better. We may use it, and disclose it to our affiliates and others, for any purpose allowed by law. For instance, we may use your information, and disclose it to others, in order to:

- Help us evaluate your request for a product or service
- Help us run our business
- Help us process claims and other transactions
- Process information for us
- Confirm or correct what we know about you
- Perform research for us
- Help us prevent fraud and other crimes
- Audit our business
- Help us comply with the law
- Doing what a court or government agency requires us to do; for example, complying with a search warrant or subpoena
- Giving information to the government so that it can decide whether you may get benefits that it will pay for
- Telling a group customer about its members' claims or cooperating in a group customer's audit of our service
- Telling your health care provider of a medical problem that you have but may not be aware of

Generally, we will disclose only the information we consider reasonably necessary to disclose.

### You Can See and Correct our Information

Generally, we will let you review what we know about you if you ask us in writing. Because of its legal sensitivity, we will not show you anything that we learned in connection with a claim or lawsuit. Also, if the law allows us to do so, we may decide to disclose what we know about your health only through your health care provider. If you tell us that what we know about you is incorrect, we will review it. If we agree with you, we will correct our records. If we do not agree with you, you may tell us in writing, and we will include your statement in any future disclosure of information.

### Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires, among other things, that health plans protect the confidentiality and privacy of individually unidentifiable health information. The Pension Board is the plan sponsor of the UCC Health Benefits Plan ("Plan") and is committed to maintaining the privacy of your personal health information under the Plan in accordance with HIPAA privacy standards, which became effective April 14, 2003. The Plan and those administering it will use and disclose health information only as allowed by federal law. The Plan has provided you with a Notice of Privacy Practices, describing how health information about you may be used or disclosed by the Plan.

### Protected Health Information (PHI)

Protected health information (PHI) is the identifiable health information about you that is created, received, or maintained by the Plan. The privacy of your health information that is used or disclosed by the Plan is protected by HIPAA. The Plan is required by law to:

- maintain the privacy of your PHI; and
- provide you with a notice of the Plan's legal duties and privacy practices with respect to your PHI.

### How the Plan can use your PHI

The Plan may use, share, or disclose protected health information to pay your health care benefits, operate the Plan or for treatment by a health care provider. In addition, the Plan may use or disclose your information in other special circumstances described in the privacy notice. For any other purpose, the Plan will require your written authorization for the use or disclosure of your protected health information. An authorization form is available online at [www.pbucc.org](http://www.pbucc.org) or by calling Member Services at 800.642.6543.

Please return this signed and completed form by email to: [info@pbucc.org](mailto:info@pbucc.org); by fax: 212.729.2701; or mail to: Pension Boards-UCC, 475 Riverside Drive, Suite 1020, New York, NY 10115.