Hometown Health

830 Harvard Way Reno, NV 89502

PLEASE FILL OUT FORM IN INK.
(NO WHITE-OUT PLEASE)
ORIGINALS ONLY – NO FAX
Groups with 51 or more Employees

MEDICAL ASSESSMENT FORM

(ONLY VALID FOR 60 DAYS)
"ALL QUESTIONS ON **FRONT AND BACK** MUST BE ANSWERED"
Hometown Health Plan – HMO
☐ Hometown Health Providers Insurance Co. - PPO

EMPLOYEE INFORMATION

Business Name_____ Business Phone (_____) _____ - _____

Home Address of Employee_____
City State Zip

Mailing Address of Employee_____ Home Phone (_____) _____ - _____
City State Zip

Full-time Employment Date _____ Job Title_____ Job Duties _____ Hours worked per week for this firm _____

A. LIST ALL FAMILY MEMBERS TO BE INSURED

	(First) (Middle) (Last)	SEX M/F	Date of Birth Month/Day/Year	Height	Weight	Social Security Number	If last name different explain relationship*
Employee						- -	Married ☐ Single
Spouse						- -	
Child						- -	
Child						- -	
Child						- -	
Child						- -	

** If last name is different from employee, legal documentation must be provided. If additional space is needed, attach, **date and sign** a separate sheet.*

B. THE FOLLOWING QUESTIONS MUST BE ANSWERED ACCURATELY AND COMPLETELY

Has any person applying for coverage, including dependents, *ever at any time* had, been told of having, consulted a physician or practitioner, or taken medication for any of the following: *(If "yes", please circle condition and complete Section C.)*

	EMPLOYEE	DEPENDENT
1. Diabetes? (check one) ☐ Diet, ☐ Oral, ☐ Insulin	YES NO	YES NO
2. Cancer, Leukemia, Hodgkin's Disease or any form of Malignancy?	YES NO	YES NO
3. Kidney Disease, Renal Failure and/or currently on Dialysis? Have you been diagnosed with Hepatitis (check one) ☐ A, ☐ B, ☐ C or ☐ ___ , Alcoholism, Drug Abuse, Cirrhosis of the Liver, Asthma, TB, Emphysema, COPD or any type of Respiratory Disease? Used Tobacco during past 12 months (Amount per day? _____ Number of Years Smoking/Chewing? _____)	YES NO	YES NO
4. HIV or AIDS, Epilepsy, Cerebral Palsy, Multiple Sclerosis, Back/Neck/Spinal Disorder, Rheumatoid Arthritis, Ulcerative Colitis, Intestinal Disorder, Heart Attack, Heart Disease or Disorder, Aneurysm, Stroke, Mitral Valve Prolapse, Lupus or Arteriosclerosis?	YES NO	YES NO
5. Have you or any of your dependents ever had a transplant or been advised to have a transplant? If so, which organ?_____	YES NO	YES NO
6. Been advised within the past year to have Surgery or to be Hospitalized for any condition?	YES NO	YES NO
7. Are you or your dependents (including children) currently Pregnant? If yes, Due Date: _____ Have you or any of your dependents had any Complications of Pregnancy including Caesarean Section and/or Premature Delivery or have been or are being treated for Infertility?	YES NO	YES NO

C. IF ANSWER IS "YES" TO ANY OF THE QUESTIONS IN SECTIONS B, GIVE COMPLETE DETAILS BELOW (Write N/A if not applicable):

Question Number	Person	Medical Condition	Treatment/Medication (For Drug/Alcoholism or Tobacco provide date and duration of last consumption below)	Dates Treated or Consulted with Doctor FROM MO/YR TO MO/YR	Degree of Recovery

*If additional space is needed, attach, **date and sign** a separate sheet.*

Please provide **COMPLETE** names and addresses of all attending doctors, hospitals and clinics and the medical condition for which treatment was received.

_____ _____ (____)____-_____ _____
Name of Doctor (including Family Practitioner)/Hospital/Clinic Address Phone Number Medical Condition

_____ _____ (____)____-_____ _____
Name of Doctor (including Family Practitioner)/Hospital/Clinic Address Phone Number Medical Condition

Signature of Employee: _____ Date: _____ Signature of Spouse:_____ Date: _____

E. IMPORTANT □ APPLICANT'S STATEMENT □ *PLEASE READ CAREFULLY*:

I represent that all answers given, including those on the front of this application, are full, complete and true to the best of my knowledge, information and belief. When applicable, I authorize my employer to deduct premiums from my earnings. I understand that any material misstatement or failure to provide requested information may be used as a basis of termination of my coverage. I understand that no coverage will be effective until this application has been approved by HHP. I understand that this information is not valid after 60 days from completion.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION: I authorize any physician, medical practitioner, hospital, clinic, veterans administration facility, other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc. or Consumer Reporting Agency having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my minor children and any other non-medical information of me or my minor children to give to the insurer or their legal representatives, any and all such information.

I understand the information obtained by use of the authorization will be used to evaluate the overall medical risk of the group coverage and ascertain any pre-existing conditions, if applicable. Any information obtained will not be released by the administrator to any person or organization except to insuring companies, the Medical Information Bureau, Inc. or other persons or organizations performing business or legal services in connection with my application, claim or as may be otherwise lawfully required or as I may further authorize.

I acknowledge that information to be released may include alcohol and/or drug abuse or psychiatric information that is protected by Federal regulations; my signature authorizes release of such information.

I further acknowledge that information to be released may also include HIV test results and/or Acquired Immune Deficiency Syndrome diagnosis.

I know that I may request to receive a copy of this authorization. I agree that a photographic copy of this authorization shall be as valid as the original. I agree that this authorization shall be valid for two and one half years from the date shown below.

Signature of Employee: _____ Date: _____ Signature of Spouse:_____ Date: _____

Any information disclosed cannot be used to deny group medical coverage.

Rev. April 2004