Health Statement **required** for **10 or less** Employees

BlueCross BlueShield of South Carolina
An Independent Licensee of the Blue Cross and Blue Shield Association

Companion Life

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

Name of Employer: _____

If you elect to refuse your employer sponsored coverage, check the block, date and sign the bottom of this form.

☐ - Refusal Reason: ☐ Medicare ☐ Medicaid ☐ Military Retiree ☐ Other _____
(Explain)

Employee Height:____ft._____in. / Weight:_____lbs. Spouse Height:____ft._____in. / Weight:_____lbs.

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1. In the last five (5) years, have you or your dependent(s) enrolling for coverage been diagnosed with, treated for, advised to seek follow-up, treatment or testing for, had symptoms of, or been hospitalized or institutionalized for any of the following:
   - Physical or mental abnormality, condition, injury, disease or disorder (other than flu or colds); deformity; birth defect; organ or tissue transplant; test abnormality; or a current pregnancy? ☐Yes ☐No
     - If pregnant, due date: _____
     - Are multiple births expected or is there a history of pregnancy complications? ☐Yes ☐No
2. Have you taken, been given or been prescribed any prescription medications in the last 12 months? ☐Yes ☐No

NOTE: If you answered "Yes" to any questions, give full details below. For more room, attach a sheet of paper, sign and date it.

Question Number	Patient Name	Condition, Injury, Symptom or Diagnosis	Date of Onset	Date of Recovery	Date Last Seen	Treatment, Test, Labs, Surgery, Medication & Dosage	Physician/Hospital name, Address, Phone Number

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 group insurance and that such insurance will not become effective until Blue Cross and Blue Shield of South Carolina and/or Companion Life Insurance have approved such application.

_____ _____
Employee Signature Date

_____ _____ _____
Print Spouse Name (if applicable) Spouse Signature (if possible and applicable) Date