# State Of Louisiana

Office of Group Benefits
and
Health Maintenance Organizations

## ACKNOWLEDGMENT OF PRE-EXISTING CONDITION AND STATEMENT OF PHYSICAL CONDITION

Applicants must complete all sections on front and back of form. Please print or type.

Employee's Name:_____ Telephone: Home _____

Street Address: _____ Telephone: Work _____

City, State, Zip: _____ Social Security Number: _____

Date of Birth _____ Agency Name _____ Agency Number _____

## ACKNOWLEDGMENT OF PRE-EXISTING CONDITION

I, _____, acknowledge that my application to _____
name name of health plan

for health coverage will be approved on a conditional basis, unless the Portability Law applies. My application, dated _____, is for the marked level of coverage.

- ☐ employee only
- ☐ employee and spouse
- ☐ employee and child(ren)
- ☐ family

I understand that such conditional approval may exclude benefit payments and coverage for a period of 12 months following the effective date of the employee/dependent coverage for pre-existing conditions. Pregnancy is not considered a pre-existing condition.

I understand that any disease, illness, accident, or injury will be classified as a pre-existing condition if, during the six-month period preceding the effective date of coverage, treatment or services were received or drugs were prescribed for such disease, accident, illness, or injury.

The term treatment shall mean all steps taken to effect the cure of a disease, illness, accident, or injury and shall include, but not be limited to, consultations, examinations, diagnosis, and any application of remedies.

I accept the conditional approval for coverage and agree that this declaration will become a part of my application for coverage.

I certify that the statements and answers given on this application are true and complete. I authorize any physician or other person in a professional capacity to disclose to such extent as may be lawful any information acquired while attending any of the persons named on the reverse side. I understand that my participation shall not take effect until this application has been approved by the health plan.

Signature of Employee Date

Signature of Witness Date

Signature of Witness Date

| TO BE COMPLETED BY HEALTH PLAN |
|---|
| Effective Date |
| By |
| Date Entered |

# STATEMENT OF PHYSICAL CONDITION

Type of Coverage ☐ employee only ☐ employee and child(ren) ☐ employee and spouse ☐ family

Mental Health/Substance Abuse Rider ☐ yes ☐ no

Include all persons applying for coverage. Attach additional sheets if necessary.

| **Employee Name** | Sex | Date Of Birth | Age | Height | Weight |
|---|---|---|---|---|---|
| Name and Address of Physician | | | | | Date Last Seen |
| **Name of Dependent** | Sex | Date Of Birth | Age | Height | Weight |
| Name and Address of Physician | | | | | Date Last Seen |
| **Name of Dependent** | Sex | Date Of Birth | Age | Height | Weight |
| Name and Address of Physician | | | | | Date Last Seen |
| **Name of Dependent** | Sex | Date Of Birth | Age | Height | Weight |
| Name and Address of Physician | | | | | Date Last Seen |

To the best of your knowledge and belief, have you or any of the persons named above been medically treated or medically advised of any of the following within the lst six months:

| Yes | No | Condition | First Name and Birthdate of Person Treated or Advised |
|---|---|---|---|
| | | A. Alcohol/Substance Abuse | |
| | | B. Epilepsy | |
| | | C. Nervous, Mental, or Emotional Condition | |
| | | D. Abnormal Blood Pressure | |
| | | E. Heart Condition(s) | |
| | | F. Blood or Circulatory Condition(s) including disorders of the immune system such as AIDS | |
| | | G. Lung or Respiratory Condition(s) | |
| | | H. Ulcer of Stomach or Duodenum | |
| | | I. Rectal/Colon Condition(s) | |
| | | J. Gallbladder Condition(s) | |
| | | K. Digestive Condition(s) | |
| | | L. Kidney or Urinary Tract Condition(s) | |
| | | M. Thyroid Condition(s) | |
| | | N. Diabetes | |
| | | O. Gout | |
| | | P. Eye Condition(s) | |
| | | Q. Ear Condition(s) | |
| | | R. Arthritis, Rheumatism | |
| | | S. Disorder(s) of Back, Spine, Bones, Muscles, or Joints | |
| | | T. Cancer, Tumor, Abnormal Growth(s) | |
| | | U. Skin Condition(s) | |
| | | MALE ONLY V. Disorder of Prostate or Reproductive Organs/Genital Organs | |
| | | FEMALE ONLY W. Pregnant Now? If yes, give anticipated delivery date. | |
| | | X. Do you now have or have you ever had any reproductive organ/genital disorder or breast disease? | |
| | | Y. Other (Specify) | |

☐ Yes ☐ No To the best of your knowledge and belief, within the last six months have you or any of the persons named above had any physical impairment, deformity, sickness, operation, injury, or check-up not listed above?

Complete the following for each "yes" answer in the questions above. Attach additional sheets if necessary.

| Patient's First Name | Medical Condition | Date Last Seen | Result ☐ Still Being Treated ☐ Released | Name/Address of Physician or Hospital |
|---|---|---|---|---|
| Patient's First Name | Medical Condition | Date Last Seen | Result ☐ Still Being Treated ☐ Released | Name/Address of Physician or Hospital |
| Patient's First Name | Medical Condition | Date Last Seen | Result ☐ Still Being Treated ☐ Released | Name/Address of Physician or Hospital |
| Patient's First Name | Medical Condition | Date Last Seen | Result ☐ Still Being Treated ☐ Released | Name/Address of Physician or Hospital |