



Allegiance Life & Health Insurance Company Inc.
 2806 S. Garfield Street
 Missoula, MT 59806 1-800-737-3137

GINA HEALTH STATEMENT DISCLAIMER

Pursuant to the requirements of the Genetic Information Non-Discrimination Act (GINA), the information being requested in this form is being used only in the process of establishing rates for the person to whom the requested information applies and it is not used for any other purpose or applied to any other individual listed on this application for any purpose.

Large Group Enrollment Application

Section One: Applicant(s) Information – (Use additional paper if necessary)

Employer		Date of Hire		
Last Name	First Name	MI	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Social Security Number	Date of Birth (mm/dd/yy)		Email Address	
Mailing Address		City	State	Zip

List all family members who are to be covered and who have had other health coverage within the past 63 days.

***Eligible Dependent** means a spouse, an unmarried child under the age of 25 who is either a natural child, stepchild, legally adopted child, or a child placed with the applicant for adoption, and who is not currently enrolled in any other individual health insurance or group health plan, or is eligible for coverage as an employee under a group health plan.*

Spouse/Dependent Information – complete for all family members to be covered

Last Name	First Name	MI	Date of Birth (mm/dd/yy)	Gender M/F	Social Security Number	Relationship to applicant

I. Please list current height and weight for all persons to be covered over the age of 12.

Name of Person	Height (ft/in)	Weight (lbs)	Name of Person	Height (ft/in)	Weight (lbs)

II. Does any family member, whether to be covered or not, have reason to believe that she or he is an expectant parent (by positive result of laboratory results, provider test, home pregnancy test, etc.)? Yes No
 If Yes, Name and relationship of expectant person _____ due date _____
 Single Fetus Multiple Fetus
 Please explain any signs of complications.

III. Is anyone to be covered currently in the hospital or other medical or rehabilitation facility? Yes No
 If Yes, name of person in facility, facility name and address, duration of stay, and diagnosis for treatment?

IV. Has anyone to be covered been informed that they have a condition for which an organ transplant may be performed?
 Yes No
 If Yes, name of person, diagnosis and possible transplant date.

V. Has anyone to be covered been informed that they require surgery that has not been performed? Yes No
 If Yes, name of person, diagnosis and possible date for surgery.

VI. Has any person to be covered EVER been diagnosed with, or treated, counseled for, or had any complaint, condition, disorder, illness, or disease relating to any of the following? Yes No If yes, please explain below.

- | | |
|--|--|
| 1. <input type="checkbox"/> AIDS or AIDS related complex
2. <input type="checkbox"/> Alcohol or Drug Use
3. <input type="checkbox"/> Blood or Coagulation Disorder
4. <input type="checkbox"/> Cancer (specify type)
5. <input type="checkbox"/> Colon or Intestinal Disorder
6. <input type="checkbox"/> Congenital Defects
7. <input type="checkbox"/> Diabetes
8. <input type="checkbox"/> Heart Problems (e.g. blocked arteries, murmur, etc) | 9. <input type="checkbox"/> HIV Positive
10. <input type="checkbox"/> Liver Disease or Disorders
11. <input type="checkbox"/> Mental Disease
12. <input type="checkbox"/> Rheumatic Fever
13. <input type="checkbox"/> Seizure Disorder/Epilepsy
14. <input type="checkbox"/> Stroke or Circulatory Problems
15. <input type="checkbox"/> Tumor (specify type)
16. <input type="checkbox"/> Weight Loss Procedure (e.g. Gastric bypass) |
|--|--|

Condition Number (1-16)	Hospitalized? Yes or No	Name of Person	Diagnosis	Dates (From/To)	Complete Provider/ Facility Name & Address

VII. Within the past 3 years, have medications (except antibiotics) been prescribed or taken for any person to be covered? Yes No If Yes, please list the medications below. (Use additional paper if necessary)

Name of person	Medication (dosage & how often refilled)	Condition for which medication was prescribed or taken	Dates Meds Taken From / To (mm/dd/yy)	Complete Provider/ Facility Name & Address

VIII. Has any person to be covered received or been recommended to receive any medical treatment that has not been listed as part of this application? This includes counseling, follow-up for abnormal laboratory studies (including abnormal pap smears), examinations/tests/laboratory studies/x-rays (MRI, CT scan, ECG, ultrasound, mammogram, etc.) or care recommended by physicians, other medical practitioners, or a legal authority. Yes No If Yes, please explain whether the treatment has been received or recommended, and provide date(s), name(s) of person(s), and detailed explanation(s).

IX. Has any person to be covered been fitted with any implants or orthopedic device (including pins, screws, plates, or braces) or does any person regularly use durable medical equipment (e.g. wheelchair, splints or crutches, oxygen, CPAP)? Yes No If Yes, please provide date(s), name(s), of person(s), and detailed explanation(s). Also note whether orthopedic device(s), is/are temporary or permanent.

Section Two: Employees Signature

I understand that the coverage I am applying for is subject to specific eligibility and enrollment requirements. The answers to the above questions are true and complete to the best of my knowledge and belief.

Employee Signature

Date

