

STATE OF LOUISIANA
 STATE EMPLOYEES GROUP BENEFITS PROGRAM
 and
 HEALTH MAINTENANCE ORGANIZATION (HMO)

ACKNOWLEDGMENT OF PRE-EXISTING CONDITION
 AND
 STATEMENT OF PHYSICAL CONDITION

APPLICANTS MUST COMPLETE ALL SECTIONS ON FRONT AND BACK (PLEASE TYPE OR PRINT)

EMPLOYEE'S NAME AND ADDRESS		TELEPHONE NO. WORK () HOME ()	SOCIAL SECURITY NO. / /
DATE OF BIRTH / /	AGENCY NAME	AGENCY NO.	

ACKNOWLEDGMENT OF PRE-EXISTING CONDITION

I, _____, acknowledge that my application,
NAME
 dated ____ / ____ / ____, to _____,

for health coverage will be approved on a conditional NAME OF HEALTH PLAN basis (unless the Portability Law applies) for:
 EMPLOYEE ONLY COVERAGE
 DEPENDENT (S) COVERAGE
 EMPLOYEE + DEPENDENT(S) COVERAGE

I understand that such conditional approval will **exclude** benefit payments and coverage for a period of 24 months following the effective date of the employee/dependent coverage in connection with a pre-existing condition (unless the Portability Law applies).

I understand that a disease, illness, accident, or injury will be classified as a **pre-existing condition** if, during the **12 month** period preceding the effective date of coverage, treatment or services were received or drugs were prescribed for such disease, illness, accident, 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, diagnoses, 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 complete and true. 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 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

1. TYPE COVERAGE

Employee Only Family Employee + 1 Dependent
 Medical Coverage
 Substance Abuse Yes No
 Mental Health/
 Catastrophic \$5,000 Employee \$5,000 Employee + Dependent \$10,000 Employee \$10,000 Employee + Dependent
 Illness

2. INCLUDE ALL PERSONS APPLYING FOR COVERAGE (Attach additional sheets, if necessary)

A. NAME	AGE	HEIGHT	WEIGHT	DATE LAST SEEN	B. NAME	AGE	HEIGHT	WEIGHT	DATE LAST SEEN	C. NAME	AGE	HEIGHT	WEIGHT	DATE LAST SEEN	D. NAME	AGE	HEIGHT	WEIGHT	DATE LAST SEEN	NAME AND ADDRESS OF PHYSICIAN

3. TO THE BEST OF YOUR KNOWLEDGE AND BELIEF, HAVE YOU OR ANY OF THE PERSONS NAMED ABOVE EVER BEEN MEDICALLY TREATED OR MEDICALLY ADVISED OF ANY OF THE FOLLOWING:

YES	NO	CONDITION	FIRST NAME AND BIRTHDATE OF PERSON TREATED OR ADVISED
		A. Alcohol/Substance Abuse	
		B. Epilepsy	
		C. Nervous, Mental or Emotional Condition(s)	
		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)	
		V. Disorder of Prostate or Reproductive Organs/Genital Organs	
		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)	

4. Yes **To the best of your knowledge and belief, within the last five (5) years, have you or any of the persons named above ever** **No had any physical impairment, deformity, sickness, operation, injury, or checkup not listed in question 3?**

5. COMPLETE THE FOLLOWING FOR EACH "YES" ANSWER IN QUESTIONS 3 AND 4. (Attach additional sheets, if necessary).

Question #	PATIENT'S FIRST NAME	MEDICAL CONDITION	DATE LAST SEEN	RESULT	NAME/ADDRESS OF PHYSICIAN OR HOSPITAL
Question #				<input type="checkbox"/> Released <input type="checkbox"/> Still being treated	
Question #				<input type="checkbox"/> Released <input type="checkbox"/> Still being treated	
Question #				<input type="checkbox"/> Released <input type="checkbox"/> Still being treated	
Question #				<input type="checkbox"/> Released <input type="checkbox"/> Still being treated	