Print Form

Group number: 561416	Last name:	First name:

Evidence of Health Status

Relationship	Last name, First name MI	Height (ft / in)	Weight (lbs.)	Disabled? If yes, indicate reason.		SSN #
Employee		/		❍ N ❍ Y	Reason:	
Spouse		/		❍ N ❍ Y	Reason:	
Child		/		❍ N ❍ Y	Reason:	
Child		/		❍ N ❍ Y	Reason:	
Child		/		❍ N ❍ Y	Reason:	
Other (specify):		/		❍ N ❍ Y	Reason:	

This information should not be submitted more than 60 days prior to the effective date.
Complete this section for applicants requesting Life insurance over the guarantee issue amount and all late enrollees applying for Life coverage.

1. Are you or any dependent currently under any treatment or prescribed medications?	❍ N ❍ Y
2. Within the past 5 years, have you or any eligible dependent to be covered been diagnosed with, counseled, consulted or treated by a doctor for any of the following:	
a Coronary artery disease, chest pain, or any disease of the arteries or blood vessels; phlebitis; high blood pressure?	❍ N ❍ Y
b Nervous, mental or emotional disorder; convulsions; epilepsy; unconsciousness?	❍ N ❍ Y
c Asthma or other disease of lungs or respiratory organs?	❍ N ❍ Y
d Kidney stones; disease of kidney, bladder, male or female organs; or infertility?	❍ N ❍ Y
e Cancer, and/or cancerous tumor? (state type & part of body in details section below)	❍ N ❍ Y
f Diabetes; liver or thyroid disease; or enlargement of the lymph nodes?	❍ N ❍ Y
g Stomach, gall bladder, intestinal or colon disorders?	❍ N ❍ Y
h Rheumatoid arthritis or back disorders?	❍ N ❍ Y
i Paralysis, or any other physical impairment or deformity?	❍ N ❍ Y
j Alcoholism or drug habit, or been a member of Alcoholics Anonymous?	❍ N ❍ Y
3. Have you or any dependent been diagnosed or received treatment for an immune system disorder (i.e. Lupus, ITP), AIDS or an AIDS-related complex?	❍ N ❍ Y
4. During the past 5 years, have you or any dependent had hospitalization or surgery scheduled or completed, had any injury, illness, medical attention or medical advice or treatment for any reason not already mentioned?	❍ N ❍ Y
5. Are you or any dependent to be covered pregnant?	❍ N ❍ Y

If you answered "yes" to any of the questions above, please provide details below and specify the question #. Attach additional signed and dated sheets if necessary.

Question # & letter	Person treated (Last name, First name)
Condition	Treatments received
Medications prescribed	Current or future treatments or medications
Date diagnosed _ _ / _ _ / _ _ _ _	Date last seen by a doctor _ _ / _ _ / _ _ _ _

Question # & letter	Person treated (Last name, First name)
Condition	Treatments received
Medications prescribed	Current or future treatments or medications
Date diagnosed _ _ / _ _ / _ _ _ _	Date last seen by a doctor _ _ / _ _ / _ _ _ _

Signature - please sign below if enrolling or waiving group coverage.

If you decide not to sign this authorization, Humana cannot complete your plan enrollment or determine your premium rate due to the inability to obtain the necessary information.

Employee or legal representative signature: _____ Date: _____

Name and relationship of legal representative: _____

Spouse signature: _____ Date: _____

(Only if selecting Life coverage over the guarantee issue amount.)

Print Form Reset Form