PRESBYTERIAN
Health Plan

Individual Assessment Form

(To be used for 51+ size groups when detailed experience data is not available)

The information provided on this statement is to be used by Presbyterian Health Plan Underwriting to evaluate your medical risk potential. The information will be kept confidential.

Name:_____ Employer:_____

Current Coverage: Single_____ EE+spouse_____ EE + Child(ren)_____ #_____ Family_____

	Employee	**Spouse**	**Phone #:**	**Work**	**Home**
Height/Weight:	____/_____	____/_____		_____	_____
Date of Birth:	_____	_____			

Are you enrolled as an employee? Yes____ No___Are you enrolled as a COBRA participant? Yes__ No ____

To the best of your knowledge:

1. Have you or dependent incurred claims greater than $5,000 in the last 12 months? Yes_____ No____.
   If yes, give details, treatment & diagnosis_____

2. Have you or dependent had, or is anticipating an organ or bone marrow transplant? Yes____ No____
   If yes, give date, treatment & diagnosis_____

3. Have you or dependent had Cancer, Heart disease, Diabetes, AIDS, HIV, Renal Failure, Liver disease (including hepatitis)? Yes____ No_____
   If yes, give date, treatment & diagnosis_____

   Do you or dependent have any neurological condition such as Multiple Sclerosis, Cerebral Palsy, Guillain Barre', or Lou Gehrig's disease? Yes____ No____ If yes give date, treatment & diagnosis_____
   _____

4. Are you or dependent currently pregnant? Yes_____ No_____
   If yes list due dates and any complications if known..._____

5. Do you or dependent have or had a history of mental illness or drug abuse including alcohol?
   Yes____ No _____ If yes give date, treatment & prognosis_____

6 Is there any medical condition or procedure that has been advised by a physician but has not yet been done?
   Please specify_____.

7. Are you or dependent taking any medications or have taken any for 30 days or more during the past year?
   Yes____ No_____ If yes, please list medication and related condition_____

By signing below, I certify that the answers provided are correct, complete and wholly true to the best of my knowledge and belief. I understand that any information omitted, misrepresented or incorrectly stated on this questionnaire may, at the sole discretion of Presbyterian Health Plan, result in enrollment being null and void.
I have answered all questions.

Employee Signature_____ Date_____

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