

PIEDMONT COMMUNITY HEALTHCARE, INC.

Piedmont Community HealthCare, Inc. is a subsidiary of
Piedmont Community Health Plan, Inc.

**Individual Health Form
For Employers with 2 to 25 Employees Enrolled**

**Please complete ALL of the following items. Your application cannot be processed until this form has been completed.
Please print your responses.**

Employee Name: (First) _____ (MI) _____ (Last) _____
 Male Female Social Security Number: _____ Birth Date (Month/Day/Year): _____
 Street Address (Residence): _____
 City: _____ State: _____ Zip Code: _____
 Daytime Phone # (including area code): _____ Evening Phone # (including area code): _____

Coverage Type:

- Employee Only
- Employee/Child
- Employee/Children
- Employee/Spouse
- Family

Information below **MUST BE COMPLETED**

Employer's Group Name:	_____
Employer's Group Number:	_____
Employee's Occupation:	_____
Date Employed:	_____
How many hours do you work for this employer per week?	_____

*** Please complete the bottom of page 1 for everyone applying for coverage with Piedmont Community HealthCare.**

Have you or any of your dependents ever been covered by Piedmont Community Health Plan or Piedmont Community HealthCare?

- Yes No

Are any of your dependents covered by your employer's group plan as a result of COBRA?

- Yes No

If yes, please provide details below (Attach additional sheets if necessary).

Name	Relationship	Effective Dates	Qualifying Event

Is anyone to be covered currently hospitalized or disabled?

- Yes No

If yes, please provide details below (Attach additional sheets if necessary).

Name	Relationship	Dates	Reason for hospitalization/disability	Prognosis

The following information MUST BE COMPLETED for all those applying for coverage, INCLUDING YOU.

Attach additional sheets if necessary. (Complete dependent information only if applying for dependent coverage.)

Name	Relationship	Birth Date	Height	Weight	# Alcoholic Drinks Per Week If Any

HEALTH INFORMATION: Please complete the following information for all those applying for coverage.

Please provide complete details in the space provided on page 3 for any condition checked in question # 1 or for any "Yes" answer given for questions 2 through 9. Attach additional sheets if necessary. (Complete dependent information only if applying for dependent coverage.)

1. Please check the box if you or any person to be covered under your policy has been diagnosed with, treated for, had treatment recommended for, or had indications of any of the following conditions within the last ten years.

- | | |
|---|--|
| <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Infertility/Difficulty getting pregnant |
| <input type="checkbox"/> Asthma/ Bronchial/ Lung Condition | <input type="checkbox"/> Kidney Disease/Kidney Stones |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Liver Disorder |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Lupus/Connective Tissue Disorder |
| <input type="checkbox"/> Eye, Ear, Nose and Throat | <input type="checkbox"/> Mental/Nervous Disorder |
| <input type="checkbox"/> Colitis/Intestinal Disorder | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Congenital Disorder/Birth Defects | <input type="checkbox"/> Non-cancerous Tumor or Growth |
| <input type="checkbox"/> Connective Tissue Disorder | <input type="checkbox"/> Occupational Therapy |
| <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> Organ Transplant |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Condition of Spine, Discs, Joints, or Bones | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Endometriosis/Abnormal bleeding/Ovarian Cysts | <input type="checkbox"/> Prosthetic Device/Braces/Artificial Limbs |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Speech Therapy |
| <input type="checkbox"/> Gall Bladder Disease/Gall Stones | <input type="checkbox"/> Thyroid or Goiter |
| <input type="checkbox"/> Herpes, Syphilis, Gonorrhea, Other STD | <input type="checkbox"/> Ulcers or Other Stomach Disorder |
| <input type="checkbox"/> Heart Disease/Angina/Chest pain, Rapid Heartbeat | <input type="checkbox"/> Other |

2. Have you or any person to be covered under your policy been diagnosed with, treated for, had treatment recommended for, or had indications of high blood pressure within the past ten years?

Yes No

If yes, indicate the following and give complete details on page 3:

Last Reading: _____ Date of Last Reading: _____

3. Have you or any person to be covered under your policy been diagnosed as having AIDS (Acquired Immune Deficiency Syndrome), HIV (Human Immunodeficiency Virus) infection, or any other disorder of the immune system?

Yes No

4. Is anyone to be covered currently pregnant?

Yes No

Expected Due Date: _____

5. Have you or anyone to be covered under your policy ever smoked cigarettes or used any tobacco product?

Yes No

If yes, give quantity, frequency, and duration on page 3.

6. Have you or anyone to be covered under your policy received treatment for alcoholic substances or drugs, including but not limited to marijuana, cocaine, heroin, amphetamines, barbiturates, or have abused prescription drugs?

Yes No

If yes, give quantity, frequency, duration, and treatment on page 3.

7. Have you or anyone to be covered under your policy been advised by a health care provider that hospitalization or a surgical procedure is necessary or may be necessary in the future?

Yes No

8. Have you or any person to be covered under your policy been diagnosed with hearing loss?

Yes No

If yes, have hearing aids been prescribed or has a surgical procedure been performed or recommended for the ears?

Yes No

If yes, please provide details on page 3.

9. Have you or any person to be covered under your policy been examined, treated, or had treatment recommended by a physician, psychotherapist, counselor, or other health care provider within the past ten years for any illness, injury, or condition other than those stated above?

Yes No

Are you, your spouse, or dependent child(ren) currently covered by any other health care program/ health insurance?

Yes No

If yes, whom does it cover? You Your Spouse Your Child(ren) Policy/Identification No. _____

Name of Policyholder: _____ Insurance Company: _____

You Effective Date of Policy: _____ Cancellation Date: _____

Spouse Effective Date of Policy: _____ Cancellation Date: _____

Child(ren) Effective Date of Policy: _____ Cancellation Date: _____

Are you, your spouse, or dependent child(ren) currently covered by or eligible for Medicare or Medicaid?(Yes No

If yes, whom does it cover? You Your Spouse Your Child(ren) Policy/Identification No. _____

Do you have dependents who will not be covered by this program? Yes No

If yes, please list these dependents: _____

ACCEPTANCE OF COVERAGE

I hereby apply for coverage under my employer's health benefits program. I authorize persons who provide me or my dependents with health care to furnish Piedmont Community Healthcare, Inc. (Piedmont) and its representatives with whatever information or records pertaining to medical services provided to me or my dependents in order to permit Piedmont to determine medical risk classifications for coverage under the Policy. This release will be effective for the lesser of 30 months or the duration of the policy. I understand that I, or my authorized representative may request a copy of this form.

I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and I understand they are being relied on by Piedmont in accepting this application. Any person who, with the intent to defraud or knowing that he/she is facilitating a fraud, submits an application or files a claim containing a false or deceptive statement may have violated state law.

I understand that Piedmont may deny payment for my claims or cancel my coverage if Piedmont finds that false or misleading information that is material to the risk has been provided. In such a case, Piedmont may cancel my coverage without advance notice and refund premium payments retroactive to my effective date, after deducting amounts attributable to any payments already made on my behalf.

I understand that my coverage will not begin until the date shown on my identification card. I acknowledge that I have read the foregoing provisions and I expressly accept such provisions as a condition of coverage.

EMPLOYEE SIGNATURE: x _____

DATE: _____

Please complete the following information only if you are declining coverage for yourself or for any of your dependents who are eligible for coverage.

DECLINATION OF COVERAGE

I decline coverage for: Employee Child(ren) Spouse

REASON: _____

I HAVE BEEN GIVEN THE OPPORTUNITY TO PARTICIPATE IN THE GROUP HEALTH BENEFITS COVERAGE OFFERED BY MY EMPLOYER AND I HAVE REFUSED TO PARTICIPATE IN THE COVERAGE AS INDICATED ABOVE. I UNDERSTAND THAT IF COVERAGE IS DESIRED AT A LATER DATE, I MUST FURNISH, AT MY OWN EXPENSE, SATISFACTORY EVIDENCE OF INSURABILITY BEFORE COVERAGE BECOMES EFFECTIVE.

EMPLOYEE SIGNATURE: x _____

DATE: _____

OFFICE USE ONLY

Action: _____

By: _____

Date: _____

Coverage Effective Date: _____