PRESBYTERIAN

Presbyterian Health Plan, Inc.
Presbyterian Insurance Company, Inc.

Individual Medical Assessment Form – Large Group

The information provided on this form is to be used by Presbyterian Underwriting to evaluate the medical risk of a group. Such information is deemed to be Covered Information for purposes of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), P.L., 104-191. The health information provided is considered private, privileged and confidential.

	Last Name	First Name	Date of Birth	Male/Female	Height	Weight
Employee						
Spouse						
Child						
Child						
Child						

Home Phone:	Work/Cell Phone:	ZIP Code:
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 a dependent incurred claim greater than $5,000 in the last 12 months?	☐ Yes ☐ No
	If yes, provide specific diagnosis, treatment rendered and treatment date:	
2.	Have you or a dependent had, or are you or a dependent anticipating an organ or bone marrow transplant?	☐ Yes ☐ No
	If yes, name organ involved and treatment date:	
3.	Have you or a dependent been treated for AIDS/HIV, Cancer, Chronic Airway Obstruction, Diabetes, Heart Disease, Hepatitis, Liver Disease, Lupus, Renal Failure, Rheumatoid Arthritis or other Autoimmune or Connective Tissue Disease?	☐ Yes ☐ No
	If yes, circle the condition; provide specific diagnosis, treatment and treatment date:	
4.	Have you or a dependent been treated for ALS/ Lou Gehrig's Disease, Cerebral Palsy, Cystic Fibrosis, Head Injury, Hemophilia or other Blood Disorder, Multiple Sclerosis, Myasthenia Gravis, Paralysis, Parkinson's Disease or Stroke?	☐ Yes ☐ No
	If yes, circle the condition; provide specific diagnosis, treatment and treatment date:	
5.	Are you or a dependent currently pregnant?	☐ Yes ☐ No
	If yes, provide the due date and current complications if any:	
6.	Have you or a dependent been treated for Mental Illness/Psychotic Disorder or Drug Abuse including Alcoholism?	☐ Yes ☐ No
	If yes, provide specific diagnosis/drug, treatment, date of treatment and specify if hospitalization was required:	
7.	Do you or a dependent have a condition not previously listed above, which may lead to treatment, surgery or hospitalization in the future?	☐ Yes ☐ No
	If yes, provide specific diagnosis, treatment or surgical procedure and treatment date if known:	
8.	Are you or a dependent taking any medications or have taken any for 30 days or more during the past year?	☐ Yes ☐ No
	If yes, please list medication(s) 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. By completing this form, I understand that I warrant and represent my current and continuing authority to act on behalf of myself and all dependents listed above. Coverage is subject to preexisting condition exclusions, waiting periods, creditable coverage periods and affiliation periods as allowed by New Mexico law. Premium, price or charge differentials because of gender or age based on objective, valid and up-to-date statistical and actuarial data are not prohibited. I understand that any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Employee Signature _____ Date _____