



**The Episcopal Church
Medical Trust / Church Life
Insurance Corporation**

445 Fifth Avenue • New York, NY 10016
212-592-1800 • 800-480-9967
www.cpg.org

Health Statement

Instructions

A health statement, providing evidence of insurability, is required when the person to be insured is applying for late enrollment. Provide all of the information requested, have a witness sign the form, and return it with accompanying Enrollment Form, to:

Health Benefits Services
The Episcopal Church Medical Trust
445 Fifth Avenue
New York, NY 10016

1. Information About the Employee

| | | | |
|----------------------------------|------------|----|------|
| Title (The Rev., Mr., Ms., etc.) | First Name | MI | Last |
|----------------------------------|------------|----|------|

| | |
|-----------------------|---------------|
| Home Address — Street | Soc. Sec. No. |
|-----------------------|---------------|

| | | | |
|------|-------|-----|------------|
| City | State | Zip | Home Phone |
|------|-------|-----|------------|

2. Information About the Parish or Institution

Name of Parish/Institution

Street

| | | | |
|------|-------|-----|-------|
| City | State | Zip | Phone |
|------|-------|-----|-------|

3. List Those Applying for Insurance

Employee

| | | |
|---------------------------|------------------|---------------|
| _____ | _____ | _____ |
| Birth Date (Mo/Day/Yr) | Ht. (Ft./In.) | Wt. (Lbs.) |

Dependents

| | | | | | |
|-----------|-----------------------------|---------------|---------------------------|------------------|---------------|
| _____ | _____ | _____ | _____ | _____ | _____ |
| Full Name | Relationship To Employee | Soc. Sec. No. | Birth Date (Mo/Day/Yr) | Ht. (Ft./In.) | Wt. (Lbs.) |

4. Health Information

If the answer to any of the questions in this section is YES, provide the names of the individuals involved, dates, and other details. Use a separate sheet if you need additional space.

Have any of the individuals applying for insurance:

1. Ever had or been diagnosed or treated for a heart disorder, stroke or high blood pressure, tumors, diabetes, or any mental or nervous disorder, kidney or liver disease, or respiratory disorder? Yes No

Details: _____

4. Health Information (continued)

2. Been hospitalized, received surgery or medical treatment for any condition in the past 5 years?
 Yes No

Details: _____

3. Been advised to have any surgical operation not mentioned in 2? Yes No

Details (including nature of surgery and planned date): _____

4. Ever been treated or diagnosed (except for HIV testing) by a member of the medical profession for:

Aids (Acquired Immune Deficiency Syndrome) Yes No

ARC (AIDS Related Complex), including enlargement of lymph nodes (glands), chronic diarrhea, unusual or persistent skin lesions, or unexplained infections? Yes No

Details: _____

5. Ever applied for any life, accident, or health insurance that was not granted exactly as applied for (in kind or amount of insurance, or rate)? Yes No

Details: _____

6. Had any life, accident, or health insurance cancelled or not renewed by an insurance company? Yes No

Details: _____

4. Health Information (continued)

7. Are you or is your spouse now pregnant? Yes No

Details: _____

8. Is everyone applying for insurance in good health? Yes No

Details: _____

5. Signatures (All Signatures Must Be Witnessed)

By signing this form, you certify that all of the statements and answers provided are complete and true, to the best of your knowledge. You also agree that this form, together with the Enrollment Form for insurance you have completed, constitutes your application for insurance under the group policy.

Employee's Signature

Date

To the witness: by signing this form, you certify that, to the best of your knowledge, the individual(s) applying for insurance is (are) in good health and answered all questions correctly.

Witness' Name

Witness' Signature