MAINE GUARANTEED ACCESS REINSURANCE ASSOCIATION
HEALTH ASSESSMENT FORM
INDIVIDUAL INSURANCE PLAN

Maine Law Requires:

1. **This form must be completed when purchasing an individual health insurance policy;**
2. **Eligibility for coverage will not be affected by your answers;**
3. **Premium rates for the insurance policy will not be affected by your answers (except for tobacco use); and**
4. **Information provided in this form will be held confidential.**

COMPLETE THIS FORM IN ITS ENTIRETY

PLEASE CHECK ONE: ☐ **NEW** ☐ **EXISTING-MAKE CHANGES**

1. Contact Information		
First Name:	Last Name:	M.I.
Street Address:		
City:	Daytime Tel #:	
State/Zip:	Evening Tel #:	

2. Covered Persons Information.
List yourself and all persons applying for coverage. If additional space is needed, attach separate sheets.

Last Name	First Name	M.I.	Relationship	Date of Birth MM/DD/YYYY	Sex (M/F)	Height	Weight	*Disabled? (Y/N)	**Tobacco Use (Y/N)
			Yourself						
			Spouse/Domestic Partner						
			Other Person (1)						
			Other Person (2)						
			Other Person (3)						
			Other Person (4)						
			Other Person (5)						

*** Check 'yes" if the person is receiving disability benefits from any source or is considered disabled by any government agency.**
**** Check 'yes" if the person to be covered smoked cigarettes, cigars, or a pipe or used chewing tobacco, nicotine chewing gum or snuff in the last two (2) years.**

3. Medical Information.
Have you or any person to be covered been diagnosed or received treatment in the last two (2) years for any of the following conditions?

1.	Cancer – Corpus Uterus (Endometrial Carcinoma)	☐ Yes ☐ No	5.	Congestive Heart Failure	☐ Yes ☐ No
2.	Cancer – Metastatic	☐ Yes ☐ No	6.	HIV Infection	☐ Yes ☐ No
3.	Cancer – Prostate Gland	☐ Yes ☐ No	7.	Renal Failure	☐ Yes ☐ No
4.	Chronic Obstructive Pulmonary Disease (COPD)	☐ Yes ☐ No	8.	Rheumatoid Arthritis	☐ Yes ☐ No

4. Medical Conditions and Treatment.

A. Have you or any person to be covered been diagnosed or received treatment in the last two (2) years for any of the following conditions?

1.	Cancer – Brain and Nervous System	☐ Yes ☐ No	15.	Cirrhosis of the Liver	☐ Yes ☐ No	29.	Myasthenia Gravis	☐ Yes ☐ No
2.	Cancer – Breast	☐ Yes ☐ No	16.	Coagulation Defect (Hemophilia)	☐ Yes ☐ No	30.	Myotonia	☐ Yes ☐ No
3.	Cancer – Colon/Rectum	☐ Yes ☐ No	17.	Coronary Artery Disease	☐ Yes ☐ No	31.	Parkinson's Disease	☐ Yes ☐ No
4.	Cancer – Esophagus	☐ Yes ☐ No	18.	Coronary Occlusion	☐ Yes ☐ No	32.	Polycystic Kidney Disease	☐ Yes ☐ No
5.	Cancer – Lung, Bronchi, Pleura	☐ Yes ☐ No	19.	Crohn's Disease (Inflammatory bowel disease)	☐ Yes ☐ No	33.	Psychotic Disorders	☐ Yes ☐ No
6.	Cancer – Multiple Myeloma	☐ Yes ☐ No	20.	Cystic Fibrosis	☐ Yes ☐ No	34.	Quadriplegia/Paraplegia	☐ Yes ☐ No
7.	Cancer – Myeloid Leukemia	☐ Yes ☐ No	21.	Friedreich's Ataxia	☐ Yes ☐ No	35.	Scleroderma	☐ Yes ☐ No
8.	Cancer – Ovary	☐ Yes ☐ No	22.	Heart Disease Requiring Open Heart Surgery	☐ Yes ☐ No	36.	Stroke	☐ Yes ☐ No
9.	Cancer – Pancreas	☐ Yes ☐ No	23.	Hepatitis	☐ Yes ☐ No	37.	Syringomyelia	☐ Yes ☐ No
10.	Cancer – Urinary Bladder	☐ Yes ☐ No	24.	Hodgkin's Disease (Lymphoma)	☐ Yes ☐ No	38.	Thrombosis	☐ Yes ☐ No
11.	Celiac Disease	☐ Yes ☐ No	25.	Huntington's Chorea or Huntington's Disease	☐ Yes ☐ No	39.	Ventricular Septal Defect	☐ Yes ☐ No
12.	Cerebral Palsy	☐ Yes ☐ No	26.	Hypertension	☐ Yes ☐ No	40.	Wilson's Disease	☐ Yes ☐ No
13.	Chronic Kidney Disease	☐ Yes ☐ No	27.	Insulin Dependent Diabetes	☐ Yes ☐ No			
14.	Chronic Seizure Disorders	☐ Yes ☐ No	28.	Lupus	☐ Yes ☐ No			

B. Have you or any person to be covered under this plan been advised by a physician to have major surgery, medical treatment or testing, with such treatment or testing to be scheduled in the future? ☐ Yes ☐ No

C. Provide details to any "Yes" in section 4A or 4B above. If additional space is needed, attach separate sheets.

Condition # and Name (i.e. 23. Hepatitis)	Name of Person	Description of the condition being treated and major treatments received (e.g. surgery)	Approximate Date(s) of Treatment	Was Medication Prescribed for this condition? (Y/N)	Name of Medication(s)	Complete Recovery (Y/N)

D. List medications taken by all applicants within the last two (2) years (that are not listed above). If additional space is needed, attach separate sheets.

Name of Person	Name of Medication	Dosage or Frequency of Use	Date Medication Last Taken or Ongoing	Condition Requiring Medication	Complete Recovery (Y/N)

5. Standardized Health Form Certification/Acknowledgement

I represent that all statements, answers and information I have given relating to me or my dependents is complete and correct to the best of my knowledge and belief. I understand that it is a crime to knowingly provide false, incomplete or misleading information to an insurance carrier for the purpose of defrauding the decision.

I understand that I will not be denied coverage based on my health status nor will my premium rate be affected by my health status, except my rate can be affected by tobacco use.

Signature of Applicant _____ Date _____

Signature of Spouse/domestic partner _____ Date _____
(if applying for coverage)

Signature of other insured age 18 or over _____ Date _____
(if applying for coverage)

Signature of other insured age 18 or over _____ Date _____
(if applying for coverage)