Blue Cross Blue Shield of Rhode Island

Employee Risk Appraisal

Company Name: ______________________________ Date of Hire: _____/_____/_____

Applicant's Name: ______________________________ Social Security #______________

Applicant's Address: ____
STREET

____
CITY/TOWN STATE ZIP

READ CAREFULLY BEFORE SIGNING

Blue Cross & Blue Shield of Rhode Island reserves the right to rescind and deny payment of claims retroactive to the original effective date of coverage, and thereby void the Membership Application, for any false and/or incomplete responses on any form completed in connection with obtaining and renewing insurance coverage.

I hereby certify that I have read the statements on the back of this page or they have been read to me, and the statements on the back of this page are true and complete to the best of my knowledge and belief. I understand that any intentional misrepresentation contained herein relied on by Blue Cross & Blue Shield of Rhode Island may be used to reduce or deny a claim or void the contract during the first two years of coverage, if such misrepresentation materially affects the acceptance of the risk. Also, any benefits previously extended will be subject to recovery by Blue Cross & Blue Shield of Rhode Island. I understand that a signed telefax copy of this form may be accepted by Blue Cross & Blue Shield of Rhode Island under certain extenuating circumstances. I understand that no benefits will apply until the coverage is made effective by Blue Cross & Blue Shield of Rhode Island.

By signing below I authorize any provider, physician, or hospital to give Blue Cross & Blue Shield of Rhode Island all information about my health or the health of my minor dependents for whom coverage is requested. Information requested may include treatment plans, dates of services, nature of accidents or illnesses, including mental illness and HIV, and records of surgery. The information provided will be used for underwriting purposes.

FOLD HERE

______________________________________ ____________________
Applicant's Signature Date

This Employee Risk Appraisal is a requirement in requesting insurance coverage with Blue Cross & Blue Shield of Rhode Island. It must be filled out completely and accurately. False and/or incomplete responses may affect eligibility for benefits, result in rescission of coverage and/or non-payment of claims, as described above.

INSTRUCTIONS:
1. Complete the back of this page entirely.
2. Fold in half, this side out, use glue strip to seal.

FOR BLUE CROSS USE ONLY			
STANDARD		INITIALS	DATE
ADDITIONAL			
TOTAL			
ID #			

CONFIDENTIAL

Only to be opened by or on behalf of Blue Cross & Blue Shield
Medical Underwriting Department

Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.

Applicant Marital Status: ❑ Single ❑ Married Number of Dependents:_______________

	FIRST NAME	MI	LAST NAME	MALE	FEMALE	DATE OF BIRTH MONTH DAY YEAR			
Applicant:				❑	❑	___/___/___	Height______	Weight ______	lbs.
Spouse:				❑	❑	___/___/___	Height______	Weight ______	lbs.
Dependent:				❑	❑	___/___/___	Height______	Weight ______	lbs.
Dependent:				❑	❑	___/___/___	Height______	Weight ______	lbs.
Dependent:				❑	❑	___/___/___	Height______	Weight ______	lbs.
Dependent:				❑	❑	___/___/___	Height______	Weight ______	lbs.

Have you or any other person listed on this appraisal ever had medical or surgical advice, treatment or consultation for any illness, disease, accident or injury for any of the following:

YES* **NO**

❑ ❑ **1.** Any disease or disorder of the cardiovascular system (heart, blood/lymph vessels), respiratory (nose, lungs), digestive (mouth, throat, stomach, liver, pancreas, intestines), genitourinary (kidneys, ureters, bladder, urethra, reproductive organs), central nervous (brain, spinal cord, nerves), musculoskeletal (muscles, bones), or endocrine (thyroid, glands) systems, eye, ear, or skin disease or disorder, cancer or diabetes?

❑ ❑ **2.** Alcoholism, drug or substance abuse or addiction, mental, nervous or emotional disorders?

❑ ❑ **3.** Has anyone to be covered ever been told they had or been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or AIDS related conditions, had a positive blood test for HIV, or experienced sudden weight loss, night sweats, persistent fever, malaise, mouth infections or lymph node enlargement?

IF THE ANSWER TO THIS QUESTION IS YES, AND THE PERSON ABOUT WHOM THIS INFORMATION IS BEING DISCLOSED IS AGED EIGHTEEN OR OLDER, HE OR SHE MUST AUTHORIZE THE DISCLOSURE BY SIGNING BELOW:

I, ______________________________, hereby authorize the disclosure to Blue Cross & Blue Shield of Rhode Island of any and all medical records, reports, x-rays, laboratory tests and analyses, or excerpts of any medical records or other information of any kind relating to my health, including those records and information related to my HIV status:

_______________________________________ SIGNATURE ____________________ DATE

❑ ❑ **4.** Is anyone to be covered taking any medications?

❑ ❑ **5.** Has anyone to be covered been advised that hospitalization, surgery, or treatment is necessary, or do they have any condition or symptom for which a physician has not been consulted?

❑ ❑ **6.** Has anyone to be covered had an exam or treatment for any illness, birth or congenital defect, injury, accident, disease or disorder not mentioned in the above questions?

❑ ❑ **7.** Have you or any of your dependents to be covered smoked cigarettes, cigars or a pipe in the past 12 months?

*If you answered “yes” to any of the conditions outlined in the questions above for you or any dependent to be covered, please complete the following. Attach an additional sheet of paper if more space is needed.
ADDITIONAL SHEETS ATTACHED? YES ___ NO ____

QUESTION NUMBER	NAME	NATURE OF ILLNESS OR COMPLAINT/TREATMENT OR MEDICATION	DURATION FROM: MO./YR.	DATES TO: MO./YR.	DEGREE OF RECOVERY**	NAME & ADDRESS OF PHYSICIAN OR OTHER HEALTH CARE PROVIDER

****IF NOT COMPLETELY RECOVERED, PLEASE INDICATE WHETHER YOU ARE STILL RECEIVING CARE.**

OTHER REMARKS: ____