Employee Medical Disclosure Statement Groups of 51+

The information you provide on this statement will be kept confidential. It will be used by Blue Cross and Blue Shield of New Mexico (BCBSNM) to evaluate your medical risk potential.

Name: ____

Work phone: ________________________ **Home Phone:** ____________________________

Current coverage: (Please check ✓ one)

❑ Single ❑ Employee + One ❑ Family* ❑ Employee + Children* *Number of children enrolled _____

Employee: Height _____ Weight _____ Date of birth_____________

Spouse: Height _____ Weight _____

To the best of your knowledge, have you or a dependent…

1) …incurred claims greater than $5,000 in the past 12 months? ❑ Yes ❑ No
   If yes, give details: ____

2) …had or is anticipating having an organ or bone marrow transplant? ❑ Yes ❑ No
   If yes, give details: ____

3) …had or currently have cancer, heart disease, diabetes, AIDS, HIV, liver disease (including hepatitis), or chronic mental illness? ❑ Yes ❑ No
   If yes, give details: ____

4) …had or currently have a physical or mental condition that may lead to treatment, surgery, or hospitalization? ❑ Yes ❑ No
   If yes, give details: ____

5) Are you or a dependent currently pregnant? ❑ Yes ❑ No
   If yes, list due date and any known complications:_____________________________________

6) I understand that BCBSNM's use or disclose of individually identifiable health information, whether furnished by me or obtained from other sources such as medical providers, shall be in accordance with the federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996)." ❑ Yes ❑ No
   If yes, please list medication(s) and related condition(s): ____________________________
   ____

I understand that BCBSNM must obtain information for the purpose of evaluating my application for health insurance and that my authorization is voluntary. Therefore I authorize any medical professional, hospital, clinic, or other organization or person to disclose to BCBSNM medical records or other information about advice, care, or treatment provided to me and/or my dependents. I understand that I am responsible for paying for any charges for these records. I understand that I must sign this authorization for BCBSNM to consider my application and to determine whether or not to offer coverage, and that no action will be taken on my application without my signed authorization. I understand that information obtained with my authorization may be re-disclosed by BCBSNM as permitted or required by law and may no longer be protected by the federal privacy laws.

I understand this authorization is valid from the date signed and terminates on whichever date is later, when my application is denied, or when coverage ends. I may revoke this authorization in writing, at any time. A revoked authorization does not affect BCBSNM's activities prior to receipt of the revocation. I should retain one duplicate of this authorization.

I have answered all questions.

Applicant's Signature: ____________________________________ **Date:** ________________________