Employee/Dependent Medical Disclosure Statement (Groups 51+)

The information you provide on this statement will be kept confidential. It will be used by New Mexico Health Connections to evaluate and underwrite your Employer Group coverage.

Employer Name:____

Employee Information	
Employee Name:	Employee Date of Birth:
Telephone Number:	Email Address:
Coverage Type (check one): □ Employee □ Employee + Child(ren) How many children are you enrolling?___ □ Employee + Spouse □ Family	

Medical History Questions		
Please answer the following questions regarding the medical history of you and any dependents that you will be adding to your policy (e.g., spouse and/or children). **To the best of your knowledge, have you or a dependent:**		
1. Incurred claims greater than $5,000 in the last 12 months?	☐ Yes ☐ No	If yes, please provide details:
2. Within the last 5 years, have you had or have you been advised to have treatment, hospitalization or surgery?	☐ Yes ☐ No	If yes, please provide details:
3. Had or currently have cancer, heart disease, chronic respiratory disease, diabetes, AIDS, HIV, liver disease (including hepatitis), chronic mental illness, or needed an organ or bone marrow transplant?	☐ Yes ☐ No	If yes, please provide details:
4. Are you or a dependent currently pregnant?	☐ Yes ☐ No	If yes, list due date and any known multiple births or complications:
5. Please list all current medication(s) and related conditions:		

I understand that NMHC will utilize this information for the purpose of evaluating my application for group health insurance and to determine group premium rates. I authorize that this information may be shared with NMHC and its Business Associates for purposes of underwriting, and will not be used to deny coverage. I understand that if my dependent(s) or I experience a change in health status after completing this form, or before my coverage becomes effective, it is my responsibility to notify NMHC.

I have answered all questions truthfully and understand that any misstatements or incorrect information could impact the premium rates for group coverage.

Applicant's signature: ______________________________________ Date: ____________________

Please return this form to your broker or employer in a sealed envelope.

CONFIDENTIAL