WELLCHOICE®

PRE-EXISTING CONDITION STATEMENT
2 - 5 EMPLOYEES ONLY

Company name:_____ Policy No.: _____

Company Address: _____
Street City State Zip

SECTION I: EMPLOYEE INFORMATION

Name: _____
Last First Middle Initial

Dependent Names: _____

Social Security Number: | | | | - | | | - | | | | |

Are you actively at work? ❒ Yes ❒ No If "No", explain _____

PRE-EXISTING CONDITIONS STATEMENT

Note: This information may ***ONLY*** be use to determine if a condition is a Pre-existing Condition. You ***CANNOT*** be denied coverage under the health benefits plan on the basis of accurate responses to the following questions. Carriers can only use the information to expedite the processing of claims. However, benefits, services or supplies for the treatment of a pre-existing condition may be limited for 180 days. This limitation of benefits, services and supplies applies only to employer groups with 2-5 employees and to late enrollees. Consult the agent or carrier for information on the waiving of this limitation under circumstances as provided under New Jersey Law.

Are you replacing existing coverage? Yes ❒ No ❒ If yes, _____

Name of previous carrier: _____ Plan No.: _____

Effective Date:_____ Term Date: _____

1. Have you or any dependent to be covered in the 6 months prior to the date of your coverage under the group contract will take effect had or been diagnosis having:

	Yes	No		Yes	No
a. Alcoholism, Drug Abuse	❒	❒	h. Heart Disorder or Condition or Chest Pains	❒	❒
b. Arthritis	❒	❒	i. High Blood Pressure	❒	❒
c. Back or Neck Disorder, Injury or Pain	❒	❒	j Kidney or Liver Disorder	❒	❒
d. Blood Disorder	❒	❒	k. Lung or Respiratory Disorder	❒	❒
e. Cancer or Tumors	❒	❒	l. Mental or Nervous Disorder	❒	❒
f. Diabetes	❒	❒	m. Paralysis, Stroke or Epilepsy	❒	❒
g. Gastro or Intestinal Disorder	❒	❒			

2. In the six (6) months prior to the date your coverage under the group policy will take effect, have your or any dependent to be covered:

	Yes	No
a. been examined or treated by a physician or other health care provider for any condition, illness or injury, other than as stated above.	❒	❒
b. Been advised to have treatment or surgery or testing that has not been done?	❒	❒
c. Been admitted to a hospital or other health care facility as an inpatient?	❒	❒
d. Taken prescribed medication(s)?	❒	❒

Please give details for any "Yes" answers to any parts of questions 1 or 2. Attach a separate sheet if more space is needed for answers. The separate sheet should be signed and dated.

Question No. and Letter	Name of Person	Condition	Duration of Symptoms Treatment Degree of Recovery	Date	Name and Address of Hospitals, Practitioners

NAME SIGNATURE DATE

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