

Simplified Health Statement



**TEXAS
AGRICULTURAL
COOPERATIVE
TRUST**

Employee Name:			Employer Name:
<i>Last</i>	<i>First</i>	<i>Middle Initial</i>	

If your answer is "YES" to any of the following questions, please provide details in the table below.
If you need more space than provided, you may attach an additional sheet.

- Are you or your dependent(s) currently disabled or pregnant? Yes No
- In the last twenty-four (24) months, have you or your dependent(s) been hospitalized? Yes No
- Within the past five (5) years, have you or your dependent(s) had consultation, received treatment, or been advised to have treatment or hospitalized for: cancer; tumor; stroke; diabetes; heart or vascular disease or disorder; mental or emotional disorder; blood disorder; muscular or systemic disease (such as, but not limited to, arthritis or lupus); use of alcohol or drugs; disorder of liver, kidney, lungs or respiratory system; intestines; immune system disorder including AIDS, AIDS related complex (ARC) or HIV? Yes No

IMPORTANT: THIS SECTION MUST BE COMPLETED IF YOU ANSWERED "YES" TO QUESTIONS 1, 2 OR 3 ABOVE.

Question Number	Family Member	Diagnosis	Dates	Treatment and Current Status	Physician's Name and Address
	<i>Name:</i> <i>Relationship:</i>		<i>From: / /</i> <i>To: / /</i>		
	<i>Name:</i> <i>Relationship:</i>		<i>From: / /</i> <i>To: / /</i>		
	<i>Name:</i> <i>Relationship:</i>		<i>From: / /</i> <i>To: / /</i>		
	<i>Name:</i> <i>Relationship:</i>		<i>From: / /</i> <i>To: / /</i>		

I understand that I am entitled to a copy of this form upon request. I declare the foregoing statements and answers to be true and complete to the best of my knowledge and belief. I realize that any intentional misrepresentation or omission of a material fact, including the presence of pre-existing conditions or disease, may result in rescission of my coverage. I hereby authorize and request any hospital, clinic, physician or other entity to furnish complete information regarding diagnosis, treatment, medical history and conclusions concerning the mental and physical condition of the above applicant(s) to the Texas Agricultural Cooperative Trust (TACT) plan or its assigned representatives to determine health status. Eligibility will not be based on health-status related factors. This information, including the personal information subsequently collected by the Texas Agricultural Cooperative Trust (TACT) plan or its legal representatives, may in certain circumstances be disclosed to third parties without further authorization, subject to right of access and correction with respect to all personal information collected. I accept as valid a photocopy of this authorization and my signature. This authorization will remain in effect for thirty (30) months from the date of signature.

Employee's signature (for self and any eligible dependents)

_____/_____/_____
Date