

Health Statement

Please type or print using black ink. All questions must be answered in full.



**TEXAS
AGRICULTURAL
COOPERATIVE
TRUST**

Name: Last	First	M.I.	Social Security No. - -	Group Number	Employer Name	Effective Date / /		
Mailing Address: Street	Apt. No.	City	State	Zip	Home Phone () -	Occupation/Title	Work Phone () -	Date of Hire/Full Time / /

APPLICANT INFORMATION (All eligible family members for whom coverage is applied MUST be listed below. If more space is needed, attach an additional sheet of paper to this form.)											
Applicant Number	Relation to Applicant	Name: Last	First	M.I.	Date of Birth	Gender	Height	Weight	Student?	Birthplace City, State	Current Physician Name, Address and Phone
1.	Self				/ /	<input type="checkbox"/> Male <input type="checkbox"/> Female			<input type="checkbox"/> Yes <input type="checkbox"/> No		
2.	Spouse				/ /	<input type="checkbox"/> Male <input type="checkbox"/> Female			<input type="checkbox"/> Yes <input type="checkbox"/> No		
3.	Child				/ /	<input type="checkbox"/> Male <input type="checkbox"/> Female			<input type="checkbox"/> Yes <input type="checkbox"/> No		
4.	Child				/ /	<input type="checkbox"/> Male <input type="checkbox"/> Female			<input type="checkbox"/> Yes <input type="checkbox"/> No		
5.	Child				/ /	<input type="checkbox"/> Male <input type="checkbox"/> Female			<input type="checkbox"/> Yes <input type="checkbox"/> No		
6.	Child				/ /	<input type="checkbox"/> Male <input type="checkbox"/> Female			<input type="checkbox"/> Yes <input type="checkbox"/> No		
7.	Child				/ /	<input type="checkbox"/> Male <input type="checkbox"/> Female			<input type="checkbox"/> Yes <input type="checkbox"/> No		

The following questions (1 through 13) apply to each individual applicant applying for coverage as listed above. For each "YES" answer, check the person as listed above with the condition and provide details in box 14. If additional space is needed, please attach a separate sheet of paper to this questionnaire.

1. Has any applicant listed here had diseases or disorders of the organs listed below in the last five (5) years?	If "YES" is checked, please mark which applicant number this applies to:								2. Has any applicant listed here been diagnosed or treated for any of the conditions listed below in the last five (5) years?	If "YES" is checked, please mark which applicant number this applies to:							
	1	2	3	4	5	6	7	1		2	3	4	5	6	7		
Brain or nervous system	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental and/or nervous disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reproductive system	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol and/or drug abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immune system	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood vessels	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck and/or back disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intestines	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Organ transplant	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lungs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bones	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Malaria	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
									Goiter	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
									Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
									Hernia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
									Ulcer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please answer the following questions based on each applicant's history for the past five (5) years.			If "YES" is checked, please mark which applicant number this applies to:							14. RESPONSE TO MEDICAL QUESTIONS: Please provide complete details including question number, date(s) of occurrences, diagnosis, treatment, medications and physician's name and address.
			1	2	3	4	5	6	7	
3.	Has any applicant smoked or used any form of tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4.	Has there been any examination or medical treatment received from any practitioner?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5.	Has any applicant been a patient of any hospital, clinic or sanitorium?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6.	Has any applicant's donated blood ever been rejected?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7.	Has any applicant had cosmetic or reconstructive surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8.	Has an operation been recommended or performed by a physician?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9.	Has any applicant received a prescription medication from any practitioner?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10.	Is any applicant now pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
11.	Has any applicant had or presently have any symptoms, illness, after effect, syndrome or physical impairment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
12.	To the best of your knowledge:									
a.	Has any applicant been treated for any condition not mentioned above?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
b.	Has any applicant had any condition(s) diagnosed that is not mentioned above?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
c.	Is any applicant currently being treated for any disorder or infirmity not mentioned above?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
13.	Has any applicant been declined for life or health coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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 signature (for self and any eligible dependents) Date _____/_____/_____
Spouse signature (if spouse is to be covered) Date

WARNING: It is unlawful to knowingly provide false, incomplete or misleading facts or information for the purpose of defrauding or attempting to defraud. Penalties may include imprisonment, fines, denial of coverage and civil damages.