South Carolina
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Companion Life
Companion Life is a separate life insurance company that does not provide BlueCross BlueShield of South Carolina products or services. Companion Life is solely responsible.

HEALTH STATEMENT
2 - 24 Enrolled Employees

Name: ______________________ Employee Social Security #: __ __ __ - __ __ - __ __ __ __

Name of Employer: ______________________

Employee: Height: ______ ft. _____ in. / Weight: ______ lbs. Spouse: Height: ______ ft. _____ in. / Weight ______ lbs.
(if coverage is to include spouse)

The following questions apply to **ALL** persons, including dependents, applying for coverage. Please provide details of any "yes" answers in the space provided or in an attached and signed document. In the past ten (10) years, have you or any persons listed on the application been diagnosed, treated or advised to seek treatment or testing, or had symptoms related to any of the following:

1. Blood Disorders/ Circulatory System ☐ Yes ☐ No

☐ Anemia ☐ Aneurysm ☐ Angina/Chest Pain ☐ Angioplasty/By-Pass ☐ Blood Clot ☐ Carotid Artery Disease
☐ Congestive Heart Disease ☐ Coronary Artery Disease ☐ Elevated Cholesterol/Triglycerides ☐ Heart Attack ☐ Heart Murmur
☐ Hemophilia ☐ Irregular Heartbeat ☐ Phlebitis ☐ Polycythemia Vera ☐ Sickle Cell ☐ Stroke ☐ Varicose Veins
☐ High Blood Pressure (Last three readings/date (Ex. 120 / 80 03 / 13 / 04))
1. __________ _____/_____/_____ 2. __________ _____/_____/_____ 3. __________ _____/_____/_____
Other (specify)______________________
Patient's Name______________________
Diagnosis/Treatment/Medication______________________
Current Status ______________________ Date Diagnosed ______________________
Date of Last Doctor Visit________________ Doctor's Name/Phone______________________

2. Bones/Injuries/ Muscles and Tissues ☐ Yes ☐ No

☐ Rheumatoid Arthritis ☐ Arthritis (Other) ☐ Broken/Fractured Bones ☐ Bulging/Herniated Disc ☐ Fibromyalgia
☐ Lupus ☐ Necrosis ☐ Back/Neck Disorder (specify)__________________ ☐ Other (specify)________________
Patient's Name______________________
Diagnosis/Treatment/Medication______________________
Current Status ______________________ Date Diagnosed ______________________
Date of Last Doctor Visit________________ Doctor's Name/Phone______________________

3. Congenital Anomalies/ Birth Defects ☐ Yes ☐ No

☐ Cleft Lip ☐ Cleft Palate ☐ Polycystic Kidney ☐ Spina Bifida ☐ Other (specify)______________________
Patient's Name______________________
Diagnosis/Treatment/Medication______________________
Current Status ______________________ Date Diagnosed ______________________
Date of Last Doctor Visit________________ Doctor's Name/Phone______________________

4. Digestive System ☐ Yes ☐ No

☐ Cirrhosis of Liver ☐ Hepatitis (specify type)____________ ☐ Other Liver Disorder (specify)________________
☐ Crohn's/Ulcerative Colitis ☐ Colon Disorders (specify)______________________ ☐ Gallbladder
☐ Hernia (specify type)________ ☐ Pancreatitis ☐ Reflux ☐ Ulcer (specify)________ ☐ Other (specify)__________
Patient's Name______________________
Diagnosis/Treatment/Medication______________________
Current Status ______________________ Date Diagnosed ______________________
Date of Last Doctor Visit________________ Doctor's Name/Phone______________________

5. Endocrine System ☐ Yes ☐ No

☐ Diabetes: Oral Medication______________________ Dosage______________________
Daily Insulin Dosage AM Units_______ PM Units_______
Last three Blood Sugar Readings (Ex. 140 03 / 13 / 04)
1. __________ _____/_____/_____ 2. __________ _____/_____/_____ 3. __________ _____/_____/_____
☐ Cystic Fibrosis ☐ Goiter ☐ Gout ☐ Pituitary Dwarfism ☐ Thyroid ☐ Other (specify)______________
Patient's Name______________________
Diagnosis/Treatment/Medication______________________
Current Status ______________________ Date Diagnosed ______________________
Date of Last Doctor Visit________________ Doctor's Name/Phone______________________

6. Infectious/Parasitic Conditions ☐ Yes ☐ No

☐ HIV/AIDS ☐ Sarcoidosis ☐ Tuberculosis ☐ Other (specify)______________________
Patient's Name______________________
Diagnosis/Treatment/Medication______________________
Current Status ______________________ Date Diagnosed ______________________
Date of Last Doctor Visit________________ Doctor's Name/Phone______________________

7. Mental Health Conditions/Substance Abuse ☐ Yes ☐ No

☐ Alcohol Abuse ☐ Anxiety/Depression ☐ Bipolar ☐ Drug Abuse ☐ Anorexia ☐ Bulimia
☐ Other (specify) ______________________
Patient's Name______________________
Diagnosis/Treatment/Medication______________________
Current Status ______________________ Date Diagnosed ______________________
Date of Last Doctor Visit________________ Doctor's Name/Phone______________________

(continued on back)

8. Nervous System/ Sense Organs ☐ Yes ☐ No

☐ Alzheimer's Disease ☐ Cataract ☐ Cerebral Palsy ☐ Deviated Nasal Septum ☐ Chronic Ear Infection
☐ Epilepsy/Seizures ☐ Glaucoma ☐ Headaches/Migraines ☐ Multiple Sclerosis ☐ Muscular Dystrophy
☐ Paralysis ☐ Parkinson's Disease ☐ Other (specify)__________

Patient's Name__________
Diagnosis/Treatment/Medication__________
Current Status __________ Date Diagnosed __________
Date of Last Doctor Visit__________ Doctor's Name/Phone__________

9. Reproductive System/ Urinary System ☐ Yes ☐ No

☐ Abnormal Pap Smear (Last three Pap Readings (Ex. normal 03 / 13 / 04))
1. ______ ___/___/___ 2. ______ ___/___/___ 3. ______ ___/___/___
☐ Bladder Disorder (specify) __________ ☐ Breast Disorder (specify) __________
☐ Endometriosis/Adhesions ☐ Infertility ☐ Kidney Stones ☐ Kidney Disorder (specify)__________
☐ Pregnant (due date ___/___/___) ☐ Current Pregnancy Complications
☐ Prostate Disorder (specify)__________ ☐ Other (specify)__________

Patient's Name__________
Diagnosis/Treatment/Medication__________
Current Status __________ Date Diagnosed __________
Date of Last Doctor Visit__________ Doctor's Name/Phone__________

10. Respiratory System ☐ Yes ☐ No

☐ Allergies ☐ Asthma ☐ Chronic Sinusitis ☐ Emphysema ☐ Chronic Bronchitis ☐ Pneumonia
☐ Shortness of Breath ☐ Sleep Apnea ☐ Other (specify) __________

Patient's Name__________
Diagnosis/Treatment/Medication__________
Current Status __________ Date Diagnosed __________
Date of Last Doctor Visit__________ Doctor's Name/Phone__________

11. Transplant ☐ Yes ☐ No

☐ Organ (type(s)) __________ ☐ Bone Marrow
Surgery Advised or Pending ☐ Yes ☐ No Surgery Completed ☐ Yes ☐ No Date Completed__________
Other (specify)__________

Patient's Name__________
Diagnosis/Treatment/Medication__________
Current Status __________ Date Diagnosed __________
Date of Last Doctor Visit__________ Doctor's Name/Phone__________

12. Tumor/Cancer/Polyps/ Cyst ☐ Yes ☐ No

☐ Brain ☐ Breast ☐ Colon ☐ Hodgkin's Disease ☐ Leukemia/Lymphoma ☐ Lung ☐ Melanoma
☐ Pancreatic ☐ Polyps (specify type)__________ ☐ Prostate ☐ Sarcoma ☐ Testicular ☐ Other (specify)__________

Patient Name's__________ Date Diagnosed __________
Stage/Level __________ ☐ Malignant ☐ Benign
Diagnosis/Treatment/Medication__________
Current Status __________ Date Diagnosed __________
Date of Last Doctor Visit__________ Doctor's Name/Phone__________

13. Symptoms, Conditions or Treatment not listed above ☐ Yes ☐ No

☐ Abnormal Lab, Test or Physical Exam Results ☐ Pain, Discomfort or Abnormality Not Yet Seen by a Physician
☐ Treatment or Surgery Advised But Not Yet Done Condition__________

Patient's Name__________
Diagnosis/Treatment/Medication__________
Current Status __________ Date Diagnosed __________
Date of Last Doctor Visit__________ Doctor's Name/Phone__________

14. Current Medication ☐ Yes ☐ No

Medication __________	Medication __________	Medication __________
Patient's Name __________	Patient's Name __________	Patient's Name __________
Diagnosis __________	Diagnosis __________	Diagnosis __________

I hereby agree that the answer to each of the above questions is complete and true, that such answers have been fully and correctly recorded, and that no material information concerning the person's past or present health has been omitted. I agree that such answers will form part of my application for group insurance, and that such insurance will not become effective until such application has been approved by Blue Cross and Blue Shield of South Carolina and/or Companion Life Insurance Company.

PRINT NAME__________

SIGNATURE__________ DATE__________