

Universal/Uniform Medical Assessment Form (Group size 2+) Employer Group Name: _____

This information is used to evaluate the medical risk of a group and may be provided to the following carriers to be used in accordance with each Health Plan's Underwriting Guidelines:

BCBSNM¹ Lovelace Health Plan² Presbyterian³ Principal⁴ United Healthcare⁵
¹ Blue Cross and Blue Shield of New Mexico is a Division of Health Care Service Corporation, a Mutual Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

² Health benefit plans offered/insured by Lovelace Health System, Inc. or its subsidiary, Lovelace Insurance Company. ³ Presbyterian Health Plan and Presbyterian Insurance Company, Inc. ⁴ Principal Life Insurance Company ⁵ United Healthcare Insurance Company

	Last Name	First Name	Date of Birth	Male/Female	Height	Weight
Employee						
Spouse						
Child						
Child						

Home Phone: _____ - _____ Work Phone: _____ - _____ Cell: _____ - _____ Zip: _____

Directions: Please check a Yes or No for each question. If any box is checked "Yes," circle the condition (e.g. stroke) and give details below in the "Details of Medical History" section. **For additional space you may use a separate sheet of paper.** Please indicate if you or any dependents to be covered have been advised, diagnosed, treated or hospitalized by a physician in the past 5 years for any of the following: **Yes No**

1. Heart (if in last 10 yrs), Stroke, Circulatory, Vascular Disease, High Blood Pressure, High Cholesterol/Triglycerides		
2. Cancer (if in last 10 yrs), Tumors, Cysts, Leukemia, Lupus or any other Systemic Disease Type/Location (if applicable) _____		
3. Multiple Sclerosis, Cerebral Palsy, Paralysis, Bone/Joint/Back or Muscle Disorders, Gout, Arthritis, Rheumatoid Arthritis – joint(s) affected: _____		
4. Allergies, Asthma, Emphysema, Respiratory or Lung Disorders, Chronic Obstructive Pulmonary Disease (COPD)		
5. Eye Disorder, Cataracts, Ear, Nose, Sinus, Tonsil, Adenoid		
6. Diabetes (specify type _____, HBA1C reading _____), Insulin Pump, Pancreas, Thyroid, Growth Disorders or Endocrine Disorder		
7. AIDS, HIV, Sexually Transmitted Diseases, Immune System Disorders or Blood Disorders		
8. Hepatitis (specify type _____), Cirrhosis, Liver Disorder, Digestive System Disorder, Colon Disorder, Hernia, Gallbladder, Crohn's Disease, GERD, Colitis		
9. Kidney, End Stage Renal Disease, Bladder, Prostate, Reproductive Organs Disorder, Hysterectomy, or Seeking Treatment for Infertility		
10. Migraines, Brain/Nervous System, Brain/Head Trauma, Seizure Disorders, Mental/Emotional Disorders, Depression, Suicide Attempt(s), Alcohol/Drug/Substance Abuse or Dependency. If Epileptic, date of last seizure: ____/____/____		
11. Organ, Tissue or Bone Marrow Transplant (within your lifetime)		
12. Are you, your spouse, or any dependents to be covered currently pregnant? Due date: ____/____/____ Expecting multiple fetuses? <input type="checkbox"/> Yes <input type="checkbox"/> No Were previous pregnancies preterm, complicated or high risk? <input type="checkbox"/> Yes <input type="checkbox"/> No		
13. Fractures, Bone(s) Involved: Surgery Involved? <input type="checkbox"/> Yes <input type="checkbox"/> No Date(s) of treatment: _____		
14. Is any person to be covered currently taking any prescription medication(s), except contraceptives to prevent pregnancy? If "yes" provide details below in the "Details of Medications" section.		
15. Have you been hospitalized, had surgery or been treated at a facility in the past 12 months?		
16. Is there any condition not previously listed that has been a medical concern?		
17. Is there any medical treatment or procedure that has been advised, but not yet done?		
18. Have you used cigarettes or other tobacco products in the past 24 months? Specify member: _____		

DETAILS OF MEDICAL HISTORY (Please be as specific as possible)

Question #	Employee/Dependent Name	Condition/Diagnosis	Disclose Past, Current & Anticipated Treatment	Date of Onset	Treatment Date(s)	Recovery Date

DETAILS OF MEDICATIONS

Employee/Dependent Name	Name of Medication	Condition for which prescribed	Currently Taking?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

By signing below I certify that the answers provided are correct, complete and wholly true to the best of my knowledge and belief. I hereby authorize the release of or use of my protected health information to insurance carriers listed on this form for the purpose of evaluating the medical risk of the employer group of which I am a part. By completing this form I understand that I warrant and represent my current and continuing authority to act on behalf of myself and all dependent(s) listed above. Coverage is subject to preexisting condition exclusions, waiting periods, creditable coverage periods, and affiliation periods as allowed by New Mexico law. Premium, price or charge differentials because of gender or age based on objective, valid, and up-to-date statistical and actuarial data are not prohibited. I understand that any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

LHP 661-0309 LINC 111-0309 UMAF Ver20090209 Employee Signature: _____ Date: _____