



In Connecticut, Anthem Blue Cross and Blue Shield is a trade name of Anthem Health Plans, Inc., an independent licensee of the Blue Cross and Blue Shield Association. ®Registered marks of the Blue Cross and Blue Shield Association.

## HEALTH STATEMENT FOR MEDICARE SUPPLEMENT COVERAGE PLANS H AND J

**This health statement is a requirement when requesting Plan H or Plan J Medicare Supplement coverage with Anthem Blue Cross and Blue Shield.** Completion of this health statement is **not** required if you are applying for coverage within six (6) months of your Medicare Part B effective date. It must be filled out completely and accurately. False and/or incomplete responses may affect eligibility for benefits and/or non-payment of claims.

### INFORMATION ABOUT YOU (PLEASE PRINT OR TYPE)

**Internal Use Only**

APPLICANT'S NAME (Last/First/Middle Initial)		SOCIAL SECURITY NUMBER		Membership Number
ADDRESS (Number & Street)		(City)	(State)	(Zip Code)
SEX	<input type="checkbox"/> Male <input type="checkbox"/> Female	TELEPHONE NUMBER (     )     -		BIRTHDATE (Mo./Day/Yr.)
				Effective Date

### PLEASE ANSWER EACH HEALTH QUESTION LISTED BELOW COMPLETELY AND ACCURATELY:

- 1) Are you currently confined or has confinement been recommended to a bed, hospital or nursing facility? YES \_\_\_\_\_ NO \_\_\_\_\_
  
- 2) Do you spend more than 50% of your day dependent upon a wheelchair, walker or supplemental oxygen? YES \_\_\_\_\_ NO \_\_\_\_\_
  
- 3) Within the **last two (2) years** have you:
  - a) Been hospitalized three (3) or more times? YES \_\_\_\_\_ NO \_\_\_\_\_
  
  - b) Been confined to a nursing home for two (2) weeks? YES \_\_\_\_\_ NO \_\_\_\_\_
  
  - c) Been advised to have kidney dialysis, joint replacement or surgery for the heart, arteries or intestines that has not yet been done? YES \_\_\_\_\_ NO \_\_\_\_\_
  
  - d) Had or been treated for Parkinson's disease, internal cancer, leukemia, Hodgkin's disease, nephritis, kidney failure, heart attack, congestive heart failure, breathing difficulty, stroke or any brain disorder? YES \_\_\_\_\_ NO \_\_\_\_\_
  
- 4) Do you have or have you ever had Alzheimer's disease, other mental disability, heart valve replacement, cirrhosis of the liver, organ transplant, or complications of diabetes such as amputation or loss of sight? YES \_\_\_\_\_ NO \_\_\_\_\_
  
- 5) Have you been advised by a medical provider that you need to be hospitalized, have surgery or have diagnostic tests for any conditions? YES \_\_\_\_\_ NO \_\_\_\_\_



