

Medical Report

Individual Underwriting Department
 P.O. Box 9041
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Each person on the Individual Enrollment Application must submit a separate completed Medical Report.

Applicant Name

Medical History – This form must be completed in its entirety by a licensed physician.

Date of Exam: _____ (must be within 12 months of application date)

Please check any of the following as they apply and provide dates, hospitalization, and other pertinent details in the space provided under "Explanation" below. You may also include copies of the patient's medical records.

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|--|--|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Pulmonary Disease | <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Counseling |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Neurological Disorder |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Participation in a drug or alcohol rehabilitation program | <input type="checkbox"/> Other injuries, surgeries or illnesses |
| <input type="checkbox"/> Diabetes Mellitus | | |
| <input type="checkbox"/> AIDS/ARC | | |

Explanation: _____

Does this patient have any future surgery or hospitalization planned? Yes No If yes, please explain: _____

Is the patient currently on any medication(s)? Yes No If yes, indicate name, dosage and reason for medication(s): _____

Laboratory

List the following laboratory results or attach a copy of the lab report(s):

Cholesterol	Date: _____	Results: TC _____	HDL _____	LDL _____
Triglycerides	Date: _____	Results: _____		
Blood sugar	Date: _____	Results: _____		
Hematocrit or Hemoglobin Only	Date: _____	Results: _____		
Serum Creatinine	Date: _____	Results: _____		

Physical Examination

Age	Height	Weight	Pulse	Respiration	BP
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Please indicate (+) if abnormal or (-) if normal as they apply and provide details in space provided.

HEENT	Hearing	Abdomen	Neurological	Heart
Sight	Skin	GU	Lungs	OB/GYN

Explanation of any abnormal findings: _____

Name of Attending Physician (Please Print)	Degree/Licensure	Telephone
Street Address	City	State
Signature	Provider Number	Date

Si usted necesita ayuda en español para entender éste documento, puede solicitarla gratis llamando al número de servicio al cliente que aparece en su tarjeta de identificación o en su folleto de inscripción.