ARIZONA PUBLIC EMPLOYER HEALTH POOL
UNDERWRITING DISCLOSURE FORM

NAME OF EMPLOYER: _____

Disclosure is intended to apply to and required for covered persons who are eligible for medical benefits under your plan at this point in time. Covered persons include Active employees, those on FMLA, short term disability or extended leave, dependents of Active employees, former active and/or dependents of COBRA beneficiaries and retirees, or any other individuals covered under extended active service provisions or severance agreements.

SECTION 1:

Are you aware of any employee, dependent, or COBRA employee who:	**YES**	**NO**
A. Is currently disabled?		
B. Incurred expenses of $30,000 or more in the last 12 months?		
C. Has been advised that necessary surgery or hospitalization is required (including pregnancy)?		
D. Has had an organ transplant such as kidney, liver, heart or lung or is on a transplant list?		
E. Are any employees currently being treated or diagnosed for the following conditions: (please check the box and list the number of employees):	**Check box**	**# of employees**
Cancer	☐	
Heart/lung disease	☐	
High blood pressure	☐	
Diabetes	☐	
Muscular skeletal condition	☐	
AIDS	☐	
AIDS Related Complex (ARC)	☐	
Hemophilia	☐	
Leukemia	☐	
Severe cardiovascular disease	☐	
Any disorder of the immune system or enzyme disorder	☐	
Any severe disorder of a major organ system	☐	
Severe burns	☐	
Renal Failure	☐	
Trauma	☐	
Any form of paralysis	☐	
Premature infancy	☐	
Bariatric surgery (completed or contemplated)	☐	
F. Has been diagnosed or is being treated for any other known serious medical condition?		

If any of the above questions have been answered “yes”, please list on the next page.

Please be aware that the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) permit the release of Protected Health Information (PHI) for the purpose of evaluating and accepting risk associated with the Insured as part of “Healthcare Operations”.

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SECTION 2:

Item No. (from Section 1)	Currently Covered by Plan (Y/N)	Age and Gender	Status (employee, spouse, child)	Diagnosis	Most Recent Date of Service	Amount Paid	Prognosis

Signature:_____ Date Completed: _____

Name (please print):_____ Title:_____

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