



# MEBA BENEFIT PLANS

MEBA MEDICAL & BENEFITS PLAN  
 MEBA PENSION TRUST  
 MEBA TRAINING PLAN  
 MEBA VACATION PLAN

1007 EASTERN AVENUE, BALTIMORE, MARYLAND 21202-4345 • (410) 547-9111

## STATEMENT OF HEALTH

**This form must accompany your Election if you are requesting a waiver of the two-year filing period.**

### Section 1

Name of Participant: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

\_\_\_\_\_

Telephone No.: \_\_\_\_\_ Expected Retirement Date: \_\_\_\_\_

Cell Phone No.: \_\_\_\_\_

### Section 2

If you have had an examination at a MEBA Diagnostic Center within the past 12 months, indicate the date and location of your last examination and complete the attached authorization for release of health information.

DATE OF LATEST DIAGNOSTIC CENTER EXAMINATION:

DIAGNOSTIC CENTER LOCATION AT WHICH YOU WERE EXAMINED:

\_\_\_\_\_  
Month

\_\_\_\_\_  
Year

\_\_\_\_\_  
City

\_\_\_\_\_  
State

### Section 3

All questions must be answered "Yes" or "No". If you answer "Yes" to any question, give details at the end of this section.

		Yes or No
1.	Has any application on your life for life, accident or sickness insurance been declined, postponed or modified?	
2.	Has any claim ever been made or have any payments or benefits been received for your sickness or injury?	
3.	Have you ever had: <ul style="list-style-type: none"> <li>(a) Any surgical operation?</li> <li>(b) Surgery advised but not performed?</li> <li>(c) X-Ray or Electrocardiogram?</li> </ul>	_____ _____ _____

4. Have you ever had, consulted or been treated by a physician or practitioner for any of the following? (Answer "Yes" or "No" to each):

	Yes/No		Yes/No
Brain or Nerve Disease, Dizziness, Epilepsy, Severe Headache, Unconsciousness, Paralysis, Nervous Breakdown or other Nervous or Mental Disorder		Indigestion, Ulcers, Colitis, Diarrhea, Rectal Disease, Hemorrhoids, Hernia, Gall Bladder, or Liver Disease or Jaundice	
Lung Disease, Pleurisy, Chronic Cough or Asthma		Albumin, Sugar, Blood or Pus in Urine	
Blood Vessel Disease or Varicose Veins		Arthritis, Allergy, Skin Disease or Syphilis	
Heart Disease, Pain in Chest, Coronary Artery Disease, Angina Pectoris or Rheumatic Fever		Kidney, Bladder or Prostate Disease, Colic, Stone or other Diseases of the Genito-Urinary Organs.	
Increased or Abnormal Blood Pressure		Cancer, Tumor, Thyroid Disease or Diabetes	
Eye or Ear or Speech Impairment		Back Impairment, Amputation or Body Deformity	

Give full details of Questions 1 through 4 answered "Yes". Specify dates, duration, severity, results, the names and addresses of any physicians, hospitals, etc. Indicate Number of Question to which details apply.

I hereby certify that all the above statements are true and correct to the best of my knowledge and belief.

\_\_\_\_\_  
Participant's Signature

\_\_\_\_\_  
Date



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# Authorization for the Use and Disclosure of Protected Health Information

### MEBA Medical & Benefits Plan

1007 Eastern Avenue  
Baltimore, MD 21202  
(800) 811-6322

As required by the Health Information Portability and Accountability Act of 1996 the MEBA Medical & Benefits Plan may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning to this office.

### AUTHORIZATION SECTION

I, \_\_\_\_\_ (print name) hereby authorize the use and disclosure of the following health information that pertains to me:

my most current Diagnostic Center Examination

for the following purpose<s>:

review of my Statement of Health submitted to the MEBA Pension Trust

I authorize the following persons to make these disclosures of my health information:

Diagnostic Center staff

I authorize the following persons to receive these disclosures of my health information:

MEBA Pension Trust and/or designee for review of Statements of Health

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected.

I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to the attention of the Privacy Official at the address noted on page one of this form. I further understand that any such revocation does not apply to the

extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

I understand that this authorization will automatically expire after review of my Statement of Health.  
indicate a date or event

I understand that I am under no obligation to sign this authorization. I further understand that my eligibility for benefits will not depend in any way on whether I sign this authorization or not.

I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**REVOCATION SECTION**

I hereby revoke this authorization.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date