MEBA Benefit Plans
Safeguarding MEBA Members and Families

1007 Eastern Avenue
Baltimore, Maryland 21202-4345
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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: _____`_____SSN (LAST 4 DIGITS): XXX-XX-_____

ADDRESS: _____ DATE OF BIRTH: _____

_____

CELL PHONE # _____ EMAIL ADDRESS: _____

EXPECTED RETIREMENT DATE: _____

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 THE RELEASE OF HEALTH INFORMATION.
- DATE OF LATEST DIAGNOSTIC CENTER EXAM: _____ (MONTH) _____ (YEAR)
- DIAGNOSTIC CENTER LOCATION WHERE YOU WERE EXAMINED:

  ◯ BALTIMORE, MD ◯ OAKLAND, CA

- IF YOU HAVEN'T HAD AN EXAMINATION AT A MEBA DIAGNOSTIC CENTER IN THE LAST 12 MONTHS, THE PLAN WILL REQUIRE A HISTORY AND PHYSICAL (H&P) COMPLETED WITHIN THAT TIMEFRAME.

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.

1.	Has any application on your life for life, accident or sickness insurance been declined, postponed or modified?			○ Yes ○ No
2.	Has any claim ever been made or have any payments or benefits been received for your sickness or injury?			○ Yes ○ No
3.	Have you ever had:			
	a. Any surgical operation?			○ Yes ○ No
	b. Surgery advised but not performed?			○ Yes ○ No
	c. X-Ray or Electrocardiogram			○ Yes ○ No
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):			
	Brain or Nerve Disease, Dizziness, Epilepsy, Severe Headache, Unconsciousness, Paralysis, Nervous Breakdown or other Nervous or Mental Disorder	○ Yes ○ No	Indigestion, Ulcers, Colitis, Diarrhea, Rectal Disease, Hemorrhoids, Hernia, Gall Bladder, or Liver Disease or Jaundice	○ Yes ○ No
	Lung Disease, Pleurisy, Chronic Cough or Asthma	○ Yes ○ No	Albumin, Sugar, Blood or Pus in Urine	○ Yes ○ No
	Blood Vessel Disease or Varicose Veins	○ Yes ○ No	Arthritis, Allergy, Skin Disease or Syphilis	○ Yes ○ No
	Heart Disease, Pain in Chest, Coronary Artery Disease, Angina Pectoris or Rheumatic Fever	○ Yes ○ No	Kidney, Bladder or Prostate Disease, Colic, Stone or other Diseases of the Genito-Urinary Organs.	○ Yes ○ No
	Increased or Abnormal Blood Pressure	○ Yes ○ No	Cancer, Tumor, Thyroid Disease or Diabetes	○ Yes ○ No
	Eye or Ear or Speech Impairment	○ Yes ○ No	Back Impairment, Amputation or Body Deformity	○ Yes ○ No

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: _____