NTCA BENEFITS
THE RURAL BROADBAND ASSOCIATION
Your Trusted Employee Benefits Partner

Statement of Health Condition
Group Health Program (GHP)

This form must be completed when an employer applies for admission to the medical plan under the NTCA Group Health Program (GHP). All employees, retirees, directors, and retained attorneys of a newly-applying employer must complete this form, regardless of whether they, or their dependents, will be enrolling in the GHP coverage on their first entitlement date. (Note: Employees can maintain the confidentiality of their medical information by submitting the "Statement of Health Condition" form to their employer in a sealed envelope for forwarding to NTCA's Asheville, N.C. office.)

APPLICANT INFORMATION

First Name _____ MI _____ Last Name _____

SSN _____ Date of Birth _____ Height _____ Weight _____

Address _____

City _____ State _____ Zip Code _____

Phone # _____ E-mail _____

DEPENDENT COVERAGE

Please complete the following even if the dependent(s) will not be immediately enrolled.

Dependent Name	Relationship	Date of Birth	Height	Weight

HEALTH CONDITIONS

List any illnesses, injury, physical, or psychological condition for which you or the Dependent(s) listed above received treatment, care, medication or advice or you had specific knowledge of the existence of during the six month period immediately preceding date this form is completed. Prepare, sign and attach additional sheets if needed.

Name	Illness/Injury	Treatment	Date

I hereby represent and agree that the foregoing information, together with any explanations, are to the best of my knowledge and belief, true and complete, and are statements of fact and not opinion.

Applicant Signature _____ Date _____

Member Company Name _____ Company # _____

NTCA Use Only	
Initials _____	Date _____

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