



NORTHWESTERN UNIVERSITY

# Short Term Disability Plan Statement of Good Health Application

## PERSONAL INFORMATION

NAME: Last First M.I.			SOCIAL SECURITY # ____ - ____ - ____		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female
HOME ADDRESS: Street Apt. City State Zip					
E-MAIL ADDRESS:			HOME PHONE: (____) ____ - ____		CAMPUS PHONE: __ - ____
DATE OF BIRTH: __ / __ / ____	DATE OF HIRE: __ / __ / ____	PHYSICIAN NAME, ADDRESS & TELEPHONE NUMBER:			

## CONFIDENTIALITY OF INFORMATION

In evaluating your application for Short Term Disability (STD) coverage, we will rely primarily on the health information you furnish to us on this form. However, the University reserves the right to request that you take a physical examination, or request additional medical information about you from any of the sources specified in the authorization section on the back side of this form. All of the information you provide on this form will be treated as confidential, and will not be disclosed to others without your prior written authorization, except to the extent necessary for the conduct of our business, and not contrary to any law. In general, you have a right to learn the nature and substance of any information in our STD files about you. You also have the right of access to such STD files (except information which relates to a claim or a civil or criminal proceeding), and to request correction, amendment or deletion of recorded personal information in those files. We may elect, however, to disclose details of any medical information you request to your attending physician. In the event we are unable to reach a decision on your application for STD coverage within 6 months due to insufficient health information, we reserve the right to request a new Evidence of Good Health application.

## HEALTH STATUS INFORMATION – Section A

Please answer the following questions on your current and past health status by checking the applicable boxes.

Yes	No	Within the past 10 years, has there been any disease/impairment of, or treatment for, any of the following? If "Yes," check appropriate box(es) and explain in Section B on the back side of this form.																																				
<input type="checkbox"/>	<input type="checkbox"/>	<table border="0"> <tr> <td><input type="checkbox"/> AIDS/AIDS-Related Complex</td> <td><input type="checkbox"/> Brain</td> <td><input type="checkbox"/> Immune System Disorder</td> <td><input type="checkbox"/> Rheumatic Fever</td> </tr> <tr> <td><input type="checkbox"/> Alcoholism</td> <td><input type="checkbox"/> Cancer</td> <td><input type="checkbox"/> Intestines</td> <td><input type="checkbox"/> Seizures</td> </tr> <tr> <td><input type="checkbox"/> Arthritis</td> <td><input type="checkbox"/> Carpal Tunnel Syndrome</td> <td><input type="checkbox"/> Kidney/Bladder</td> <td><input type="checkbox"/> Skin</td> </tr> <tr> <td><input type="checkbox"/> Asthma</td> <td><input type="checkbox"/> Diabetes</td> <td><input type="checkbox"/> Liver</td> <td><input type="checkbox"/> Stroke</td> </tr> <tr> <td><input type="checkbox"/> Back/Spine/Neck</td> <td><input type="checkbox"/> Ears/Eyes</td> <td><input type="checkbox"/> Lungs</td> <td><input type="checkbox"/> Substance Abuse</td> </tr> <tr> <td><input type="checkbox"/> Blood Pressure/Hypertension</td> <td><input type="checkbox"/> Epilepsy</td> <td><input type="checkbox"/> Mental/Nervous Disorder</td> <td><input type="checkbox"/> Thyroid</td> </tr> <tr> <td><input type="checkbox"/> Blood Vessels</td> <td><input type="checkbox"/> Heart</td> <td><input type="checkbox"/> Nervous System</td> <td><input type="checkbox"/> Tumor/Growth</td> </tr> <tr> <td><input type="checkbox"/> Bones</td> <td><input type="checkbox"/> Hernia</td> <td><input type="checkbox"/> Paralysis</td> <td><input type="checkbox"/> Ulcer</td> </tr> <tr> <td><input type="checkbox"/> Other (Please Explain)</td> <td colspan="3"></td> </tr> </table>	<input type="checkbox"/> AIDS/AIDS-Related Complex	<input type="checkbox"/> Brain	<input type="checkbox"/> Immune System Disorder	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Cancer	<input type="checkbox"/> Intestines	<input type="checkbox"/> Seizures	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Carpal Tunnel Syndrome	<input type="checkbox"/> Kidney/Bladder	<input type="checkbox"/> Skin	<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Liver	<input type="checkbox"/> Stroke	<input type="checkbox"/> Back/Spine/Neck	<input type="checkbox"/> Ears/Eyes	<input type="checkbox"/> Lungs	<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Blood Pressure/Hypertension	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Mental/Nervous Disorder	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Blood Vessels	<input type="checkbox"/> Heart	<input type="checkbox"/> Nervous System	<input type="checkbox"/> Tumor/Growth	<input type="checkbox"/> Bones	<input type="checkbox"/> Hernia	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Ulcer	<input type="checkbox"/> Other (Please Explain)			
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<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant?																																				
<input type="checkbox"/>	<input type="checkbox"/>	Are any inpatient or outpatient medical/surgical or dental procedures or oral surgery (including diagnostic testing) recommended or contemplated?																																				
<input type="checkbox"/>	<input type="checkbox"/>	Are you currently taking medication(s) for any condition? If "Yes," please list the medication(s) and dosage, and indicate duration of use and underlying condition.																																				
<input type="checkbox"/>	<input type="checkbox"/>	Do you use tobacco products? If "Yes," please list the number of packs per day and number of years you have smoked.																																				
		Within the Past:																																				
<input type="checkbox"/>	<input type="checkbox"/>	5 Years Have you been examined by, consulted with, or received medical treatment from any physician, dentist or practitioner for anything other than minor illnesses such as a cold, flu, etc. If "Yes," please explain in Section B.																																				
<input type="checkbox"/>	<input type="checkbox"/>	5 Years Have you been confined in a hospital, clinic, sanitarium or other treatment facility? If "Yes," please explain in Section B.																																				

