

Avera MyPlan

Health care benefits for individuals

Application for Individual Health Insurance

How to Apply:

- Please print all information and use a ballpoint pen. We cannot accept any application completed in pencil.
- If this application is for children only, the applicant must be the youngest child.
- If this application is for self plus spouse, the applicant must be the youngest spouse.
- If this applicant is under age 18, the signature and relationship of a parent or legal guardian or proof of emancipation is required.
- You must reside in the licensed Avera Health Plans' service area and be a United States citizen to be eligible for this coverage.
- Avera Health Plans must receive this application within 15 days of the date you sign it.

Policy Effective Date

- The requested effective date can be no sooner than the day following the signature date or no more than 60 days after the signature date.
- If an effective date is not selected, your effective date will be assigned based upon the approval date.
- The effective date for most changes to an existing policy with Avera Health Plans is the 1st of the month following the signature date.
- Odd effective dates are allowed for new business only.
- Child(ren) only applications covering newborns (age 0-6 months) may not have an odd effective date. The earliest available effective date would be the 1st of the month following the signature date.

Checklist

- Did you indicate which health care plan you are applying for?
- Did you indicate whether or not you are also applying for optional benefits?
- Have you completed the tobacco declaration section?
- If you want your premium automatically deducted, have you included a voided check?
- Have you checked "Yes" or "No" to each health question?
- If you made any changes to this application, did you initial that change?
- Have you signed and dated this application?



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(605) 322-4545
1 (888) 322-2115
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www.AveraHealthPlans.com



INDIVIDUAL HEALTH ENROLLMENT APPLICATION

FOR OFFICE USE ONLY	
Effective Date: ____/____/____	
Tracking #: I	County/Region

Requested Effective Date ____/____/____
 New Enrollment Change Form

1. Applicant Information

Applicant Name (Last)	(First)	(M.I.)	Social Security No (Internal Use Only)		
Street Address	City	State	Zip Code	County	
Mailing Address (if different from above)	City	State	Zip Code	County	
Home Phone	Work Phone	E-Mail Address			

In order to complete the underwriting process as soon as possible, Avera Health Plans may need to contact you. Please indicate the best method and time to contact you: Email (indicate above) Phone (day)____(evening)____ Mail Fax ()____

When is the best time to reach you? _____

Will you accept emailed documents from Avera Health Plans? Yes No

____/____/____ Male Female _____ Single Married Separated Divorced

Date of Birth _____ Height _____ Weight _____

2. Coverage Election

This request for coverage is for Self Self+One Self + Children Children Family

This plan I am applying for is:
 MyPlan #1 MyPlan #2 MyPlan #3 MyPlan #4 MyPlan HSA
Additional Options: Maternity Dental Vision Preventive

Dependent Information Complete for covered dependents only. (If more space is needed, attach an additional sheet of paper, sign and date it.)

Legal Last Name, First Name, Middle Initial	Gender (M/F)	Birth Date (M/D/Y)	Social Security No (Internal Use Only)	Relationship	If 19 or over, Full-Time Student? (Y/N)	Height/Weight	Disabled ² (Y/N)?
02 Spouse							
03 Dependent							
04 Dependent							
05 Dependent							
06 Dependent							

¹ If the dependent is 19 or older, and a full-time student, proof of full-time student status must be provided for the enrollment process.
 Do all of the dependent(s) listed above reside at the same address as the applicant? Yes No
 If no, list dependent(s) name and address: _____

² Is disabled person(s) eligible for Medicare? Yes No

Event Change Notification

If this is a change to an existing contract due to an event, check all that apply: Birth Death Marriage Divorce
 Medicare Eligible Adding/Removing Dependent Other, Specify _____
 Name of Affected Person(s): _____ Date of Event: ____/____/____

3. Previous Coverage

Does any person named on this application have previous health care coverage of 12 or more months without a lapse of 63 days or more? Yes No
(If yes, the following information must be completed to determine waiting period or coordination of benefits. Certificates of creditable coverage from your previous carrier(s) should be attached to this application. If this section is not completed, an assumption will be made that there was no prior coverage and pre-existing limitations will apply.)

Type of Policy (Group or Individual)	Covered Individuals	Effective Date	Termination Date	Insurance Co.	Policy Number

4. Other Insurance Information

a. Are you currently or have you previously been enrolled with Avera Health Plans? Yes No If yes, list Member ID# _____

b. Will you or any of your family members be covered by another health policy after the effective date of enrollment with Avera Health Plans?
 Yes No If yes, you must complete the following information to coordinate benefits.

Person Insured	Employer of Insured	Insurance Company	Policy Number	Effective Date
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List covered family members: _____

c. Is anyone named in the application eligible for Medicare/Medicaid? Yes No If yes, list Name/Medicare/Medicaid # _____

5. Health Assessment

If you or any person named in this application has **ever** been affected by or treated for cancer, please complete the section below.

Type of Cancer _____
 Diagnosis Date _____ Area of Body _____
 Surgery Yes No Dates _____
 Chemotherapy Treatment Yes No Dates: From _____ To _____
 Remission Yes No
 Follow-up Treatment _____

If you or any person named in this application has been affected by or treated in the last 10 years for any of the conditions listed below that would cause an ordinarily prudent person to seek medical advice, please put an 'X' in the box marked 'Yes' to the left of the condition described. If not, please put an 'X' in the box marked 'No' to the left of the condition described. Please review the **Description of Conditions** sheet to clarify definitions of the conditions listed below. You must furnish information about each condition listed or your application will be returned. A description of these conditions is on the back of this application. **If you change your answer, you must initial the change.**

Conditions	Yes	No	Conditions	Yes	No	Conditions	Yes	No	Condition	Yes	No
01 – Infectious Diseases			Migraine headache			Pulmonary TB			Hemorrhage during pregnancy		
AIDS			Congenital and other disorders of the central nervous system			Bronchitis			Other condition during pregnancy		
HIV			Carpal tunnel syndrome			Asthma			Ectopic pregnancy		
Septicemia			07 – Ophthalmology			Emphysema			Pregnancy, not yet delivered		
Minor infectious disease			Internal eye infection			Occupational and environmental pulmonary diseases			16 – Gynecology		
02 – Endocrinology			Conjunctivitis			Benign pulmonary neoplasm			Infection of the ovary and/or fallopian tube		
Hyper/Hypo-functioning thyroid gland			Glaucoma			Chest trauma			Infection of the uterus		
Goiter			Cataract			11 – Gastroenterology			Infection of the cervix		
Other diseases of the thyroid gland			Trauma of the eye			Infection of the stomach and esophagus			Vaginal infection		
Type I or Type II diabetes			Congenital anomaly of the eye			Gastritis and/or duodenitis			Conditions associated with menstruation		
Gout			Macular degeneration			Ulcer			Conditions associated with infertility		
Hyperlipidemia			Visual disturbances			Trauma of the stomach or esophagus			17 – Dermatology		
Obesity			08 – Cardiology			Appendicitis			Bacterial infection of the skin		
03 – Hematology			Heart transplant			Diverticulitis			Viral skin infection		
Leukemia with bone marrow transplant			Coronary artery disease			Other infectious diseases of the intestines and abdomen			Fungal skin infection		
Non-neoplastic blood disease with splenectomy			Ischemic heart disease			Trauma of the intestines and abdomen			Parasitic skin infection		
Hematology signs and symptoms			Pulmonary heart disease			Congenital anomalies of the intestines/abdomen/stomach			Inflammation of skin		
04 – Psychiatry			Congestive heart failure			Irritable bowel syndrome			Burns		
Dementia			Aortic aneurysm			Hernias, except hiatal			Skin trauma		
Autism and child psychoses			Cardiac infection			Hemorrhoids			Open wounds		
Depression			Valvular disorder			12 – Hepatology			18 – Orthopedics and Rheumatology		
Anxiety disorder and phobias			Benign hypertension			Liver transplant			Infection of the bone and joint		
Eating disorder			Cardiac congenital disorder			Hepatitis			Joint inflammation		
Attention deficit disorder			Major cardiac trauma			Cirrhosis			Joint degeneration		
Development disorder			Arterial inflammation			Pancreatitis			Open fracture		
Mental retardation			Embolism and thrombosis of the veins			Cholelithiasis			Closed fracture/dislocation		
05 – Chemical Dependency			Varicose veins of the lower extremity			13- Nephrology			Joint derangement		
Cocaine or amphetamine dependency, with complication			09 – Otolaryngology			Kidney transplant			Major trauma other than fracture		
Acute alcohol intoxication			Trauma of the oral cavity			Acute renal failure			Juvenile rheumatoid arthritis		
Alcohol dependence			Otitis media			Chronic renal failure			Adult rheumatoid arthritis		
06 – Neurology			Tonsillitis, adenoiditis or pharyngitis			Renal inflammation			Lupus		
Viral meningitis			Allergic rhinitis			Nephrotic syndrome			Bursitis or tendinitis		
Viral encephalitis			Sinusitis			14 – Urology			Orthopedic deformities		
Brain abscess			Hearing disorders			Sexually transmitted disease			Congenital anomalies		
Spinal abscess			ENT trauma			Kidney stones, with surgery			19 – Neonatology		
Epilepsy			Other ENT disorders			Urinary incontinence			Chromosomal anomalies		
Cerebral vascular accident, hemorrhagic			10 – Pulmonology Diseases			Infertility			Metabolic disorders		
Major brain trauma			Lung Transplant			15 – Obstetrics			21 – Late Effects, Environmental Trauma and Poisonings		
Spinal trauma			Viral pneumonia			Normal pregnancy			Environmental trauma		
Hereditary and degenerative diseases of the central nervous system			Bacterial lung infections			Complicated pregnancy			Poisonings and toxic effects of drugs		

If you have answered 'Yes' to any of the above questions, please indicate the name of the member and category number that applies.

Name of Member	Category Number	Dates From/To	Explain nature of illness/condition	List all treatment including medications	Family Physician	Percentage of Recovery

(Attach additional responses if necessary)

- Yes No Are there any other conditions/illnesses not listed above? Please describe: _____
- Yes No Is anyone listed on the application pregnant? If yes, list the due date: ____/____/____
- Yes No Has any future surgery, diagnostic testing or medical treatment been recommended or scheduled for anyone listed on the application? Please describe: _____
- Yes No Is anyone listed on the application taking prescription medication that is not listed previously? Please describe: _____
- Yes No Has an insurance company refused or restricted health coverage on any person listed on the application? Please explain: _____

6. Tobacco Declaration

Yes No I, my spouse and/or my dependent(s) (if included on this application) have used tobacco during the 12 months immediately preceding the date of this application. If yes, please indicate the name and relationship of the tobacco user.

If this status changes, you must notify us immediately. We may require you to recertify this status in the future. If we determine within the initial two years that this status is incorrect, we will retroactively collect historical differences in premiums before claims will be paid, and we will start applying the tobacco user rates on the first of the month following your receipt of this information.

7. Release of Information

By signing this application, I authorize any consumer reporting agency, medical information bureau, insurance company or other person having information about me or my dependents to release to Avera Health Plans or any of its designees any and all records or information pertaining to medical history, health history questions, health statement or health services rendered to me or my dependents, including drug and/or alcohol abuse information, or any information regarding responsibility for payment to Avera Health Plans, for any administrative purpose.

I also authorize Avera Health Plans, its employees and agents, to disclose records and information as permitted by law to authorized persons including other insurers or reinsurers or other vendors. Avera Health Plans may be compensated by other insurers or vendors. A copy of this authorization is as valid as the original. Unless otherwise stated or revoked by my written revocation, this authorization terminates when enrollment in Avera Health Plans terminates. This information will be used to determine eligibility for benefits, payments responsibility and utilization review. I agree to abide by the documents describing my coverage, (including but not limited to this application the Policy, Benefit Summary, identification card, and any other attached papers) and to pay any applicable premiums, co-payments, coinsurance and deductibles. I understand that my enrollment or eligibility for benefits in Avera Health Plans is conditional upon me signing this authorization and that failure to sign may result in being denied enrollment or benefits.

8. Payment

How do you want to pay for your insurance premiums?

Direct Bill. If so, on what basis? Quarterly Semi-annually Annually

Automatic Account Withdrawal. If so, on what basis?

Monthly Quarterly Semi-annually Annually

Account Type: Checking (Include a voided check) Savings (Please submit pre-printed form from your financial institution)

If payor did not sign the application, pre-authorization form is needed.

You may cancel automatic account withdrawal at any time. However, we need to receive your written notification at least 20 days before your scheduled withdrawal. If paying by automatic withdrawal from checking, please remember to include a voided check.

Agreement and Certification

I acknowledge receipt of a fully completed copy of this application and an Outline of Coverage for health benefits. I certify that I have carefully and fully read the Agreement and Certification language and the Notice to Applicant Regarding Replacement of Accident and Sickness Insurance section. I have confirmed with all persons named in this application that my signature is binding to secure coverage. I have further confirmed with all persons named in the application that in the event I am not eligible for or removed from the coverage and/or the family coverage is divided into multiple policies, my signature is binding to secure coverage. Any payment will be held until the application process is complete.

Applicant Signature X _____ Date ____/____/____

Parent/Legal Guardian Signature (if applicant is a minor) X _____ Date ____/____/____

If guardian, please provide proof of guardianship.

Parent/Legal Guardian Printed Name & relationship to applicant X _____

I have reviewed the Checklist on the coverage page and have completed all necessary sections of this application.

Producer's Signature _____ Date ____/____/____

Producer Name (please print) _____ Agency Name _____



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Notice to Applicant Regarding Replacement of Accident and Sickness Insurance

If this Avera MyPlan individual health insurance policy is intended to replace your existing health insurance, be aware of the following important points:

- a. Health conditions which you now have (known as “pre-existing conditions”) may not be immediately or fully covered under the new policy or certificate of coverage. This could result in denial or delay of payment for a claim under the new policy or certificate of coverage, whereas the same claim might have been paid under your present policy.
- b. You may want to get the advice of your present insurer or insurance agent regarding the replacement of your current policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
- c. If, after considering the above items, you still wish to terminate your present policy and replace it with the Avera MyPlan coverage, be certain to truthfully and completely answer all questions on the application concerning your medical-health history. Failure to include all vital medical information on an application may provide a basis for Avera Health Plans to deny payment for claims submitted and to refund your premium as though your policy or certificate had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information is accurate and truthful.

Agreement and Certification

I certify that I am legally authorized to apply for coverage for myself and on behalf of all other persons named in this application. I understand that I am applying for coverage as indicated on this application, providing the specified individual health information. I further understand that coverage applied for will not start until this application and the appropriate premium payment amount are received and accepted by Avera Health Plans, an effective date of coverage is established, and Avera Health Plans notifies me in writing of approval of coverage.

The coverage effective dates will be assigned as indicated on this application and can be no more than two months past the date I sign this application. Should my application not be approved, my payment will be refunded in full.

I certify that I have been informed of and understand that, if approved for enrollment into an individual Avera MyPlan policy issued to me, I and those other people covered under the insurance policy shall be subject to the following:

1. A 12-month exclusion period for all medical conditions that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the 6 months immediately preceding the effective date of coverage and all medical conditions for which medical advice, diagnosis, care or treatment was recommended or received during the 6 months immediately preceding the effective date of this policy.
2. Coverage will not be provided for pregnancy existing on the effective date of coverage.
3. Avera Health Plans will give credit towards satisfying the exclusion periods contained in the policy for which I have applied if I or any family member has had creditable coverage within the last 63 days. The other coverage must have provided substantially similar coverage. All exclusion periods contained in the policy applied for shall commence from the effective date of the policy as assigned by Avera Health Plans.

In the event I have selected Health Savings Account (HSA) coverage on this application, I understand that enrolling in HSA coverage does not guarantee that I am or will be eligible to make contributions to an HSA or that contributions can be made to an HSA on my behalf.

I understand this application is subject to medical underwriting. If I or any other person named in this application have certain health conditions, this application may be denied, coverage for certain health condition(s) may be restricted or excluded under this health care coverage, or I may be asked to pay a higher premium under this health care coverage due to certain health conditions(s).

I understand and agree that Avera Health Plans will continue the medical underwriting process up to the effective date of coverage as entered on this application or assigned by Avera Health Plans, whichever is later. This means that if a condition arises that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment or a condition arose for which medical advice, diagnosis, care or treatment was received or recommended prior to the effective date of coverage, regardless of the date I signed the application or the date the application was acted upon by the Insurers, I will so inform Avera Health Plans by sending this information in writing to:

Avera Health Plans, Inc.
Attn: Underwriting
3816 S Elmwood Avenue, Suite 100
Sioux Falls, SD 57105

I authorize any health care provider to release medical records to the insurers when reasonably related to the coverage for which I have applied. If any law or regulation requires additional authorization for release of medical records, I and any other person named in this application will give this authorization. I further agree upon request to furnish Avera Health Plans with information required to administer the requested coverage.

Premium payments may be made on a calendar month, calendar quarter, semi-annual calendar year or calendar year basis. For example, a monthly premium would be the first day of each month through the last day of such month. A quarterly payment would be for any calendar quarterly period, such as January 1 through March 31. A semi-annual payment would be for the period of either January 1 through June 30 or July 1 through December 31. An annual premium would be for January 1 through December 31 of the applicable year.

I understand that any health condition amendments previously signed and in effect on current individual coverage issued by Avera Health Plans will remain in effect under this new coverage if I am not required by Avera Health Plans to answer health questions on this application.

Description of Conditions

Infectious Diseases

AIDS – Acquired Immune Deficiency Syndrome or AIDS related complex.

HIV – Human Immunodeficiency Virus.

Septicemia – Bacterial infection of the blood.

Minor infectious disease – Treatment for minor infectious diseases.

Endocrinology

Hyper/Hypo-functioning thyroid gland – Diagnosis of hyperthyroidism or hypothyroidism.

Goiter – Enlargement of the thyroid gland.

Other diseases of the thyroid gland – Any condition of the thyroid including Graves' Disease.

Type I or Type II diabetes – Insulin resistance, hypoglycemia, glucose intolerance, metabolic syndrome, syndrome X or any blood sugars under observation or being managed by diet and/or medication.

Gout – Diagnosis or treatment of gout.

Hyperlipidemia – Diagnosis of high lipid levels to include cholesterol.

Obesity – Diagnosis or treatment of obesity.

Hematology

Leukemia with bone marrow transplant – Diagnosis of leukemia and treatment involving the replacement of bone marrow.

Non-neoplastic blood disease with splenectomy – Any diagnosis of non-neoplastic blood disease with the removal of spleen by surgery.

Hematology signs and symptoms – Past or present indications of a blood disease.

Psychiatry

Dementia – Any diagnosis of dementia.

Autism and child psychoses – Any diagnosis or treatment for Autism or child psychoses.

Depression – Any diagnosis

or treatment of depression by a health care provider, counselor or social worker.

Anxiety disorder and phobias – Any diagnosis or treatment for anxiety or phobias.

Eating disorders – Anorexia, bulimia, binge eating or other disorder characterized by disturbances in eating behavior.

Attention deficit disorder – Any learning or behavior disorder related to short attention span, impulsiveness and excessive physical movements that is present or has been treated in the past.

Development disorder – Any diagnosed disorder that occurs at some stage in a child's development, often retarding the development.

Mental retardation – Diagnosis or treatment of mental retardation.

Chemical Dependency

Cocaine or amphetamine dependency with complication – Any illegal use of amphetamines or cocaine.

Acute alcohol intoxication – Any treatment for acute alcohol intoxication.

Alcohol dependence – Any use of alcohol over two drinks per day for women and three drinks per day for men. Any treatment or counseling by a health care provider, clergy or AA.

Neurology

Viral meningitis – Any diagnosis of viral meningitis.

Viral encephalitis – Any diagnosis of the inflammation of the brain caused by a virus.

Brain abscess – Any diagnosis or treatment of a brain abscess (cerebral abscess).

Spinal abscess – Any diagnosis of inflammation around the spinal cord.

Epilepsy – Any history of seizures. Include date of last seizure.

Cerebral vascular accident, hemorrhagic – Any diagnosis of a stroke or cerebral aneurysm.

Major brain trauma – Any treatment of an injury to the brain.

Spinal trauma – Any condition of the spine including scoliosis, kyphosis herniated or bulging disc, congenital abnormality, fracture, dislocation, stenosis, spondylosis, prior back or neck surgery.

Hereditary and degenerative diseases of the central nervous system – Any diagnosis of disease of the brain or spinal cord.

Migraine headache – Migraines or cluster headaches.

Congenital and other disorders of the central nervous system – Any disorder of the brain or spinal cord.

Carpal tunnel syndrome – Treatment for or symptoms of a disorder related to nerve(s) of the hand, wrist or elbow; symptoms may include numbness, tingling, pain, weakness and/or decreased ability to grip.

Ophthalmology

Internal eye infection – Diagnosis of any internal eye infection.

Conjunctivitis – Any diagnosis or treatment of "pink eye."

Glaucoma – Disease of the optic nerve.

Cataract – Any diagnosis of the clouding of the eye's natural lens.

Trauma of the eye – Any history of injury to the eye.

Macular degeneration – Any diagnosis or treatment of macular degeneration.

Visual disturbances – Diagnosis of any visual disturbance not otherwise listed.

Cardiology

Heart transplant – Replacement of the heart.

Coronary artery disease – Any diagnosis or treatment of coronary artery disease.

Ischemic heart disease – Any diagnosis or treatment of ischemic heart disease.

Pulmonary heart disease – Any diagnosis or treatment for pulmonary heart disease.

Congestive heart failure – Any diagnosis related to heart failure.

Aortic aneurysm – Any diagnosis of swelling of the aorta.

Cardiac infection – Any diagnosis or treatment of a bacterial or viral infection of the heart.

Valvular disorder – The diagnosis or treatment of a malfunction of one or more heart valves.

Benign hypertension – High blood pressure.

Cardiac congenital disorder – Cardiac disorder present at birth.

Major cardiac trauma – Any condition requiring heart surgery.

Arterial inflammation – Any diagnosis or treatment of inflammation of the arteries.

Embolism and thrombosis of the veins – Any diagnosis of the blocking or clotting of blood vessels.

Varicose veins of the lower extremity – History of vein stripping or varicose veins requiring medical treatment.

Otolaryngology

Trauma of the oral cavity – Any history of trauma to the oral cavity.

Otitis media – Any diagnosis or treatment of otitis media (middle ear infection).

Tonsillitis, adenoiditis or pharyngitis – Any diagnosis or treatment of tonsillitis, adenoiditis or pharyngitis.

Allergic rhinitis – Any diagnosis or treatment of inflammation of the nasal passages.

Sinusitis – Chronic or multiple episodes of sinus inflammation.

Hearing disorder – Hearing loss from any cause, including the use of hearing aids or surgery done to improve hearing.

ENT trauma – Any trauma of the ear, nose or throat.

Other ENT disorders – Diagnosis of any disorders of the ear, nose or throat.

Pulmonology Diseases

Lung Transplant – Replacement of a lung.

Viral pneumonia – Diagnosis of viral pneumonia.

Bacterial lung infections – Diagnosis or treatment for a bacterial lung infections including pneumonia.

Pulmonary TB – Any diagnosis or treatment of pulmonary tuberculosis.

Bronchitis – Diagnosis of bronchitis.

Asthma – Treatment for asthma, including exercise induced asthma.

Emphysema – Any treatment for or diagnosis of emphysema or Chronic Obstructive Pulmonary Disease (COPD).

Occupational and environmental pulmonary diseases – Any diagnosis of a pulmonary disease caused by occupational or environmental factors.

Benign pulmonary neoplasm – Any diagnosis of non-malignant pulmonary neoplasm.

Chest trauma – Any history of trauma to the chest.

Gastroenterology

Infection of the stomach and esophagus – Any history of infection of the stomach or esophagus.

Gastritis and/or duodenitis – Ulcer – Any diagnosis or treatment for an ulcer.

Trauma of the stomach or esophagus – Any history of trauma to the stomach or esophagus.

Appendicitis – Any diagnosis or treatment of an inflammation of the appendix.

Diverticulitis – Any diagnosis or treatment for diverticulitis.

Other infectious diseases of the intestines and abdomen – Diagnosis or treatment of any infectious diseases of the intestines and abdomen not otherwise listed.

Trauma of the intestines and abdomen – Any history of trauma to the intestines or abdomen.

Congenital anomalies of the intestines/abdomen/ stomach – Diagnosis or treatment of congenital anomalies of the intestines, abdomen or stomach.

Irritable bowel syndrome – Diagnosis or treatment of irritable bowel syndrome.

Hernias, except hiatal – Inguinal, Incisional, Ventral, Umbilical, a bulge or protrusion that is present or has been treated.

Hemorrhoids – Any diagnosis or treatment of hemorrhoids.

Hematology

Liver transplant – Replacement of the liver.

Hepatitis – Any treatment or

positive testing for any form of hepatitis.

Cirrhosis – Chronic liver disease.

Pancreatitis – Diagnosis of pancreatitis.

Cholelithiasis – Gallbladder disease.

Nephrology

Kidney transplant – Replacement of kidney.

Acute renal failure – Rapid breakdown of kidney function.

Chronic renal failure – Gradual loss of kidney function.

Renal inflammation – Inflammation of the kidney.

Nephrotic syndrome – Diagnosis or treatment of Nephrotic syndrome (a damaged kidney allowing protein leakage from the blood into the urine).

Urology

Sexually transmitted disease – Any treatment of a sexually transmitted disease.

Kidney stones with surgery – Any past surgery to treat for kidney stones.

Urinary incontinence – Loss of bladder control.

Infertility – Problems with conception or fertilization, including artificial means of becoming pregnant.

Obstetrics

Normal pregnancy – Confirmed or suspected pregnancy; includes positive home pregnancy test or missing more than one period or presence of all or most of the symptoms of pregnancy, whether the pregnancy has been confirmed by a physician or not.

Complicated pregnancy – Hemorrhage during pregnancy – Diagnosis or treatment of hemorrhage during pregnancy.

Other conditions during pregnancy – Other conditions complicating pregnancy.

Ectopic pregnancy – History of a pregnancy in which the fertilized ovum implanted in any tissue other than the uterine wall.

Pregnancy, not yet delivered – Current pregnancy.

Gynecology

Infection of the ovary and/or fallopian tube – Any diagnosis or treatment of an infection of the ovary or fallopian tube.

Infection of the uterus – Any

diagnosis or treatment of an infection of the uterus.

Infection of the cervix – Any diagnosis or treatment of an infection of the cervix.

Vaginal infection – Any diagnosis or treatment of a vaginal infection.

Conditions associated with menstruation – Any diagnosis or treatment related to menstruation.

Conditions associated with infertility – Any diagnosis or treatment of infertility.

Dermatology

Bacterial infection of the skin – Any diagnosis or treatment of a bacterial skin infection.

Viral skin infection – Any diagnosis of a viral skin infection.

Fungal skin infection – Any diagnosis of a fungal skin infection.

Parasitic skin infection – Any diagnosis of a skin infection caused by a parasite.

Inflammation of skin – Any history of skin inflammation.

Burns – Any treatment for burns.

Skin trauma – Any history of trauma to the skin.

Open wounds – Any open wounds requiring surgery to repair.

Orthopedics and Rheumatology

Infection of the bone and joint – Diagnosis of an infection of any bone or joint.

Joint inflammation – Any history of inflammation of any joint.

Joint degeneration – Any diagnosis of degeneration of a joint(s) regardless of the cause.

Open fracture – Any history of a fracture of a bone puncturing the skin (compound fracture).

Closed fracture/dislocation – Any history of a fracture of a bone, not puncturing the skin (simple fracture).

Joint derangement – Any diagnosis or treatment of a joint derangement.

Major trauma other than fracture – Any other major trauma not already listed.

Juvenile rheumatoid arthritis – Any diagnosis or treatment of Juvenile rheumatoid arthritis.

Adult rheumatoid arthritis – Any diagnosis or treatment of adult rheumatoid arthritis.

Lupus – Any diagnosis of lupus.

Bursitis or tendonitis – Any diagnosis of bursitis or tendonitis

regardless of the cause.

Orthopedic deformities – Any diagnosis or treatment of orthopedic deformities.

Congenital anomalies – Any diagnosis or history of congenital anomalies.

Neonatology

Chromosomal anomalies – Diagnosis of Turner's Syndrome, Trisomy 21 (Down Syndrome) or any other chromosomal anomalies.

Metabolic disorders – Any diagnosis of a genetic or acquired metabolic disorder.

Late Effects, Environmental Trauma and Poisonings

Environmental trauma – Any history of trauma due to environmental exposure.

Poisonings and toxic effects of drugs – Any history of drug poisoning.

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