Navy Mutual
NAVY • MARINES COAST GUARD NOAA • USPHS
BENEFITS • INSURANCE • SINCE 1879

Basic Exam

Policy Number: _____

Name of Applicant: _____ D.O.B _____ Sex: ☐ Male ☐ Female

Address: _____ (Street) _____ (City/Town) _____ (State) _____ (Zip Code)

Family Physician: _____ Date & Reason Consulted _____

Address: _____ (Street) _____ (City/Town) _____ (State) _____ (Zip Code)

Treatment and/or Medication Prescribed? ☐ Yes ☐ No (If Yes, give details in #8 Remarks Section)

	YES	NO
1. Have you ever consulted any medical practitioner for, or so far as you know, ever been treated for:		
A. Any disorder of eyes, ears, nose or throat, including speech impairment or loss of sight?	☐	☐
B. Any disease of the lungs or respiratory tract such as bronchitis (acute or chronic), tuberculosis, emphysema, pleurisy, sarcoidosis, asthma, hayfever, spitting blood, or persistent hoarseness or coughing?	☐	☐
C. Any disorder of the heart or blood vessels, e.g., heart attack, angina pectoris, stroke, palpitations, elevated blood pressure, shortness of breath, chest pain, irregular pulse or varicose veins?	☐	☐
D. Any disease of the stomach, liver, intestines or rectum, e.g., ulcers, gallbladder disease, bleeding from intestinal tract, colitis, diverticulitis or appendicitis?	☐	☐
E. Any disorder of the prostate, bladder, kidneys or genito-urinary tract, e.g., nephritis, sugar, protein or pus in urine, venereal disease, kidney stones or colic?	☐	☐
F. Any brain or nervous system disorder, e.g., epilepsy, convulsions, dizziness, fainting or loss of consciousness, mental illness (anxiety, depression, PTSD, schizophrenia, dementia, Alzheimer's, etc.), constant nervousness or severe headaches?	☐	☐
G. Any alcoholism or excessive use of alcohol or any drug habit? Any treatment or hospitalization?	☐	☐
H. Any impairment of function, or loss of hand, neck, arm, shoulder, foot, leg or hip, or back disorder?	☐	☐
I. Anything else, e.g., cancer, cyst or tumor, blood disorder, anemia, hypoglycemia, diabetes, glandular condition, e.g., thyroid, hernia, skin disease or eczema?	☐	☐
2. Have you ever:		
A. Had a surgical operation?	☐	☐
B. Been told to have an operation that wasn't performed?	☐	☐
C. Had any diagnostic procedures, e.g. x-ray, electro-cardiogram, CT scan, MRI, etc.?	☐	☐
D. Lived with someone who has had T.B. in the last 2 years?	☐	☐
E. Had a weight change in the past year? If yes, reason? (List below)	☐	☐
F. Had a physical or mental condition that caused you to be deferred, rejected or discharged from the armed forces?	☐	☐
G. Ever applied for or received any pension or benefits for sickness, disability or accident?	☐	☐

	YES	NO
3. Other than previously stated, as far as you know, have you in the last 5 years:		
A. Had any illness, disease or injury?	☐	☐
B. Been admitted to, or been advised to enter, a hospital or sanitarium, etc.	☐	☐
C. Consulted any medical practitioner for any reason (including check-ups?)	☐	☐
D. Any reason to feel you are not in good health?	☐	☐
E. Are you taking any medication or drugs?	☐	☐
4. For women only:		
A. Are you pregnant? If yes, please give month of pregnancy, any previous pregnancies, and any complications of those pregnancies, if any. (list below)	☐	☐
B. Any disorder of the breasts or female organs?	☐	☐

5. A. Family History

Family Record	Age if Living	Condition of Health If not "Good," give details	Age at Death	Cause Of Death
Father				
Mother				
Brothers				
Sisters				

B. Any family history of diabetes, cancer, hypertension, heart or kidney disease, mental illness or suicide?	☐	☐
6. Do you participate in regular exercise? If yes, describe type and frequency. (list below)	☐	☐
7. Have you ever used any nicotine products (ie., cigarettes, cigars, pipes, chewing tobacco, snuff, nicotine gum or patches)?	☐	☐

8. Remarks: Please give full details for any questions above answered "Yes".

Question #	Dates and Duration	Physician's Name, Hospital or Company, Address, City, State and Zip Code Nature of Condition, Treatment, Results, Reasons and Other Information

Basic Exam (Continued)

9. Pulse _____ per/minute ☐ Regular ☐ Irregular

Number of Irregularities, if any _____

10. Blood Pressure

	1st Reading	2nd Reading	3rd Reading
Systolic			
Diastolic			

Blood Pressure: Record 1 reading, if systolic over 140 or diastolic over 90, take second and third readings after 10 minutes of rest.

11. Height _____ ft. _____ in. (without shoes)

Weight _____

12. Urinalysis (Dipstick)

Glucose _____

Albumin _____

13. Measurements (Males Only)

Chest at full inspiration _____

Chest at forced expiration _____

Abdomen at umbilicus _____

14. Did you weigh? ☐ Yes ☐ No

Did you measure? ☐ Yes ☐ No

15. Obvious abnormalities:

16. Remarks:

I HEREBY DECLARE that, to the best of my knowledge and belief, the information given in these answers to the Examiner is correctly recorded, complete and true, and I agree that the Company, believing them to be true, shall rely and act upon them accordingly.

Dated at _____

Witnessed by _____
Examiner

Signature of Person Examined _____

Branch Address:

_____
Please Print Name of Applicant

_____
Signature of Witness/Examiner Date

_____
Please Print Name of Witness/Examiner

This is a non-state specific generic exam form.

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Continuation of Exam

Applicant: _____ _____ _____ Date of Birth: _____
First Middle Last

Agent: _____ Policy Number: _____

Question #	Dates and Duration	Physician's Name, Hospital or Company, Address, City, State and Zip Code Nature of Condition, Treatment, Results, Reasons and Other Information

Signature of Examiner: _____ Date: _____

Branch Address: _____

_____

Frequently Asked Questions about the HIPAA-Compliant Authorization Form

What is HIPAA?

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was enacted by the United States Congress and signed by President Bill Clinton in 1996. Title I of HIPAA protects health insurance coverage for workers and their families when they change or lose their jobs. Title II of HIPAA, known as the Administrative Simplification (AS) provisions, requires the establishment of national standards for electronic health care transactions and national identifiers for providers, health insurance plans, and employers.

Why is this HIPAA-compliant authorization required?

This form is required so that Navy Mutual Aid Association may: 1) underwrite your application for coverage and make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage you currently have or have applied for with the Navy Mutual Aid Association.

How will the information be used?

Title II of HIPAA requires adhering to the Privacy Rule. The HIPAA Privacy Rule regulates the use and disclosure of certain information held by "covered entities" (generally, health care clearinghouses, employer sponsored health plans, health insurers, and medical service providers that engage in certain transactions). It establishes regulations for the use and disclosure of Protected Health Information (PHI). PHI is any information held by a covered entity which concerns health status, provision of health care, or payment for health care that can be linked to an individual. This includes any part of an individual's medical record or payment history.

When necessary, this form will be used to obtain medical records and other pertinent medical information required in connection with your application for coverage.

What if I do not sign the form?

Signing the form is voluntary, and your examination can be completed and forwarded to Navy Mutual without this form. Please understand, however, that leaving the authorization unsigned may impair Navy Mutual Aid Association's ability to process your application.

Whom can I contact for more information?

Please contact the Customer Service department at Navy Mutual Aid Association by calling 1-800-628-6011 and selecting the appropriate option.

I already signed an authorization with my original application and on the laboratory slip, why is this additional form needed?

Due to the Privacy Rule noted above, certain medical facilities require this specific form in order to process requests for medical records. In order to ensure prompt and timely service, we are requesting this form to avoid delays should additional medical information be required to process your application.

HIPAA-Compliant Authorization for Release of Medical Information

Henderson Hall ■ 29 Carpenter Road ■ Arlington, VA 22212
Phone: 800-628-6011 ■ Fax: 703-945-1441 ■ E-mail: counselor@navymutual.org ■ Website: www.navymutual.org

Name of Proposed Insured/Patient (please type or print) _____ Date of birth _____

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record, prescription history, medications prescribed and any other protected health information concerning me to the *Navy Mutual Aid Association*. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that the *Navy Mutual Aid Association* may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the *Navy Mutual Aid Association*.

This authorization shall remain in force for 36 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to the entity identified above. I understand that a revocation is not effective to the extent that any of My Providers has already relied on this Authorization to disclose information about me or to the extent that the *Navy Mutual Aid Association* has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be re-disclosed by the *Navy Mutual Aid Association* except as authorized by me or as required by law.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization, or otherwise condition my enrollment or eligibility for health benefits on my signing this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, the *Navy Mutual Aid Association* may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I understand that any authorized representative or I will receive a copy of this authorization upon request.

Signature of Proposed Insured/Patient or Personal Representative _____ Date _____

Description of Personal Representative's Authority or Relationship to Patient _____

FOR NAVY MUTUAL USE ONLY Proc # _____

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