Personal Health Questionnaire (PHQ)

Employee Name:________________________ **Employer Name:**________________________

Daytime Phone: (___)________-__________ **Date of Hire:**____________________________

Address:____________________________ **City:**__________________ **State:** ____ **Zip:** ______________

What is your marital status? (Circle one)	**Married**	**Single**
Please indicate your work status? (Circle one)	**Part Time**	**Full Time**
Are you enrolling dependents? (Circle one)	**Yes**	**No**
Are you currently actively working? If no, please indicate reason for leave and expected return to work date:	**Yes**	**No**
Are you planning to enroll in your employer's health insurance plan?	**Yes**	**No**

If you selected "No", please select one of the following, then skip the remainder of the form and sign the bottom of page 5.

Covered by Spouse's plan	☐	**Not Eligible**	☐
Do Not Want Coverage	☐	**Other Reason:**	____________________

If you are planning to enroll in your employer's health insurance plan, please complete the rest of this form. *Answer the following questions for yourself and eligible enrolling family members. Include additional sheets for detailed explanations or additional dependents. All questions must be answered, or the form will not be accepted.*

I. Demographic, Build and Tobacco Use

	Relation to Employee	Member Name	Social Security Number	Gender (M / F)	Birth Date (mm/ dd/ yyyy)	Height		Weight (lbs)	Home Zip Code	Tobacco use in last year? (Yes / No)
						Feet	In			
1	Employee									
2	Spouse									
3	Child									
4	Child									
5	Child									
6	Child									

(Continued on Next Page)

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II. Medical Conditions & Treatments

Has any person listed above seen a medical provider, had treatment recommended, received care (including prescriptions) or been hospitalized for any of the following?

***** Check "Yes" or "No" for all questions. Please complete "Additional Detail Table" on page 3 for *ALL* "Yes" answers.**

#	Condition	Yes	No
1.	**Cancer** (if yes, list location and type of cancer) ______________________________		
	If yes, check one: Stage 1 [ ] Stage 2 [ ] Stage 3 [ ] Higher [ ]		
	Date of remission (if applicable) ______________________________		
2.	**Cardiac or Heart Disease / Disorder** (If Yes, check all that apply)		
	[ ] Heart Attack		
	[ ] Bypass Surgery or angioplasty on a single vessel or,		
	[ ] Bypass Surgery or angioplasty on multiple vessels		
	[ ] Any other heart condition (e.g. arrhythmia, aneurism, heart failure, valve disorder)?		
	[ ] List here:		
3.	**Diabetes**: if yes, type 1 [ ] or Type 2 [ ]		
	If yes, list 3 most recent HbA1c / fasting blood sugar levels:		
	1 ______ 2 ______ 3 ______		
4.	**High Cholesterol**		
	If yes, list 3 most recent readings:		
	1 ______ 2 ______ 3 ______		
5.	**High Blood Pressure**		
	If yes, list 3 most recent readings		
	1 ______ 2 ______ 3 ______		
6.	**Arthritis** (e.g. rheumatoid, osteo, psoriatic, gout)		
7.	**Autoimmune Disease** e.g. lupus, MS, anemia)		
8.	**Back Disorder** (e.g. degenerative disks, herniated disk, spinal fusion, spondylitis, strain)		
9.	**Benign Growth** (e.g. tumor, cyst)		
10.	**Bowel** (e.g. irritable bowel (IBS), Crohn's, ileitis)		
11.	**Circulatory System Disease** (e.g. stroke, arterial / vascular diseases)		
12.	**Immunodeficiency** (e.g. AIDS, HIV+, hemophilia)		
13.	**Kidney Disorder** (e.g. nephritis, renal failure)		
14.	**Liver Disease** (e.g. cirrhosis, hepatitis A, B, C, E)		
15.	**Mental Illness** (e.g. mild or major depression, anxiety, bipolar disorder, or schizophrenia)		
16.	**Counselling** (Current or prior counseling)		
17.	**Muscular Disorder**		
18.	**Respiratory** (e.g. asthma, allergies, pneumonia, COPD, emphysema, bronchitis)		
19.	**Stomach** (e.g. ulcer, acid reflux, GERD)		
20.	**Substance dependency** (e.g. alcohol, drug, opioid)		
21.	**Transplants** (if yes, list organ(s):______________________________)		
22.	**Hemophilia**		
23.	Is anyone currently taking prescription drug(s)? If yes, list in additional detail table page 3		
24.	Has anyone had any of the following for a **serious illness** in the past five (5) years?		
	a. Treatment		
	b. Hospitalization or emergency room visit		
	c. Surgery		
25.	Is anyone currently:		
	a. Confined or hospitalized in a treatment facility?		
	b. Confined in a home, incapacitated or incapable of self-support?		

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II. Medical Conditions & Treatments (continued)

26. Is any of the following pending?			
a. Treatment (medical treatment or diagnostic testing)			
b. Hospitalization			
c. Surgery			
27. In the past five (5) years, has anyone enrolling had symptoms of any serious medical condition(s) not yet included in this form?			
28. How would you evaluate your current health condition?			
Excellent	Good	Fair	Poor
29. How would you evaluate the current health condition(s) of your dependent(s)?			
Excellent	Good	Fair	Poor

III. Pregnancy and Childbirth

30. Is anyone pregnant? (If no, mark “No” and skip question 29.			
a. The due date is			
b. Is this a High-Risk Pregnancy, any complications or bleeding?			
c. Previous C-Section or pre-term birth?			
d. Are multiple births expected? If so, please check one below:			
Twins	Triplets	More	

Additional Detail Table – Please fill-in Details Below for All Questions Answered “Yes”

#	Name of Individual	Condition / Diagnosis	Date of Onset	Last Date Treated	Treatment / Drug (List All)	Still taking? (Y / N)	Degree of Recovery

*** If you marked "Yes" to any item on Pages 2 and 3, please complete ADDITIONAL DETAIL TABLE above, or this form will not be accepted.**

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Agreement to Enroll for Coverage

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Instructions: please read this authorization form carefully before signing. Your request to enroll for coverage cannot be processed without your signature. You have the right to receive a copy of this form following your signature.

I. Protected Health Information

Nationwide Insurance Company and its affiliates are committed to the privacy of your PHI/Personal Information and has required all business associates and vendors to agree in writing to those same protections. Despite these efforts we are required by law to advise you that your Information may at some point fall outside of these protections, be re-disclosed and would no longer be protected.

This authorization encompasses information that is considered to be Protected Health Information and/or Personal Information. Protected Health Information (PHI) includes individually identifiable health information that is created or received by your provider, health plan or insurer, data clearinghouse, a health authority, employer, school or university, pharmacy or pharmacy benefit managers.

PHI/Personal Information relates to the past, present, or future condition of your physical or mental health, healthcare provided to you, or payment for the healthcare provided to you. PHI/Personal Information does not include summary health information or information that has been de-identified according to the standards for de-identification provided for in the Health Insurance Portability and Accountability Act privacy rule.

By signing this form, I authorize certain entities identified below to use or disclose my protected health information. Protected health information includes, but is not limited to, hospital records, physician records, lab results, mental health records and alcohol and/or drug abuse records. Protected health information may be obtained, maintained, or transmitted in any form or medium, including written, oral, or electronic.

II. Purpose of the Authorization Form

By signing this form, I authorize the use and disclosure of protected health information for the purposes of: determining eligibility for enrollment or benefits under a health plan; determining eligibility and/or risk-rating of stop-loss insurance coverage for my employer, or to allow the plan's designee to conduct utilization review and quality improvement activities ("Purpose").

III. Entities Authorized to Use and Disclose My Protected Health Information

I hereby authorize the following entities, their reinsurers, or other organizations performing business or legal services in connection with the Purpose above and their respective legal representatives ("Entities") to receive, use, and disclose my protected health information for the Purpose listed above:

The Excess Stop-Loss Insurance Company

United States Managing General Underwriters

I authorize Entities to disclose my PHI between themselves and their affiliated companies, to reinsuring companies, to the plan administrator or plan sponsor.

I further authorize any licensed physician, medical practitioner, healthcare provider, hospital, clinic, pharmacy or pharmacy benefit managers or other medical or medically related facility, insurance or reinsuring company, or other organization that has any record or knowledge of me to give Entities any and all PHI about me concerning diagnosis, treatment and prognosis for any physical or mental condition, including, but not limited to, all medical and healthcare records.

I understand I have a right to inspect and copy my own PHI/Personal Information to be used or disclosed. I understand that failure to sign this Authorization will result in my application not being considered.

I understand that my Personal Representative or I have a right to receive a copy of the authorization form. A simulated, faxed or copied image of this Authorization shall be as valid as the original.

IV. Term of Authorization

I further agree this Authorization will be valid until the Entities or their affiliates have completed their underwriting of my employer's coverage or for 12 months from the date signed, whichever is less.

V. Right to Revoke

I understand I may revoke this authorization at any time by giving advance written notice to the Entities listed above. Revocation of this authorization form will not affect actions Entities took in reliance on this form prior to receipt of the written notice of revocation.

I acknowledge and agree that if information has been intentionally omitted or misrepresented, my employer's self-funded health plan may deny or limit coverage and the Third-Party Administrator service agreement may terminate for breach. I certify that the statements above are true and correct to the best of my knowledge. I understand that this form is used for information only and does not bind coverage. United Advantage Agency gathers this information for statistical and actuarial use only. This information is not to be used in connection with any decisions or actions regarding my employment. Prospective employees in Michigan should not provide information regarding height or weight. In compliance with requirements for the Genetic Insurance Nondiscrimination Act (GINA), my Employer's Benefit Plan is not requesting genetic information. My Employer's Benefit Plan Notice of Privacy Practices provides more detailed information about how United Advantage Agency and the health plan I have chosen may use and disclose my protected health information. I have a legal right to review the Notice of Privacy Practices before I sign this consent, and I am encouraged to read it in full. I have a right to request restrictions on how my protected health information is used and disclosed. My Employer's Benefit Plan is not required by law to grant my request. However, if my request is granted, my Employer's Benefit Plan is bound by their agreement(s). I have a right to revoke this consent in writing, except to the extent my Employer's Benefit Plan has already used or disclosed my protected health information in reliance upon my consent. I will notify my Employer's Benefit Plan of any health or enrollment related changes that occur after signing this form up to the effective date of coverage on the Employer's Benefit Plan.

Employee Medical Amendment

I understand that the stop loss insurance company has the right to revise rates (retroactively or prospectively), rescind or terminate my Employer's Stop-Loss Insurance Contract if I completed these forms with false, incomplete or misleading information. The Plan or my Employer will rescind or terminate my or my dependent(s)'s coverage for fraud or intentional misrepresentation of material fact if I completed these forms with false, incomplete or misleading information. I understand that I have the opportunity to edit any of my information at this time by disclosing such information in the Employee Eligibility Statement.

I have read and agree to the attached Authorization.

Employee Signature____Date___________

Print Name ____

Group Name ____

Note: Page 6 of this document is for the employee's information and retention. It is not required nor intended to be submitted with the remainder of this questionnaire.

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IMPORTANT NOTICE: PLEASE READ AND RETAIN

Special Enrollments

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may, in the future, be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after coverage was terminated as a result of loss of eligibility for the coverage or termination of employer contribution (60 days for special enrollees who have lost their Medicaid or State Children's Health Insurance Program coverage). In addition, if you have a life-changing event, such as your marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the qualifying event. Coverage will become effective on the date of the qualifying event. Regardless, submission of an updated version of this form will be required.

Annual Open Enrollment Period

Eligible employees may enroll themselves and their eligible dependents during the annual open enrollment period, which is the month prior to the start of the new plan year.