# Personal Health Questionnaire (PHQ)

**Employee Name:** _____ **Employer Name:** _____

**Daytime Phone: (  )  -** _____ **Date of Hire:** _____

**Address:** _____ **City:** _____ **State:** _____ **Zip:** _____ **Email Address:** _____

**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 p. 3.**

☐ **Covered by Spouse's plan** ☐ **Not Eligible**

☐ **Do Not Want Coverage** ☐ **Other Reason (** _____ **)**

- ***If you selected "yes," 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 may not be accepted.*

## I. Demographic, Build and Tobacco Use

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

## II. Medical Conditions & Treatments

**Has any person listed above seen a medical provider, had treatment recommended, received care (including prescriptions) or been hosptialized for any of the following, within the last 5 years?**

***** Check "YES" or "NO" for each question. Please complete ADDITIONAL DETAIL TABLE on p. 3 for ALL "Yes" answers.**

**1. Cancer** (if yes, list location and type of cancer below) **Yes** ☐ **No** ☐

Location and type of cancer _____

**Check one:** ☐ Stage 1, ☐ Stage 2, ☐ Stage 3, ☐ higher

Date of remission (if applicable):

**2. Cardiac or Heart Disease / Disorder** **Yes** ☐ **No** ☐

**If yes, check all that apply:**

☐ heart attack,

☐ bypass surgery or angioplasty on **single** vessel, or

☐ bypass surgery or angioplasty on **multiple** vessels;

☐ **ANY other heart conditions (list here):** _____

(i.e. arrhythmia, aneurysm, heart failure, heart valve disorder)

**3. Diabetes** (if yes, list type 1 or 2) ☐ **Yes** ☐ **No**

**Type:** _____

If yes, list 3 most recent HbA1c / fasting blood sugar levels:

1) 2) 3)

**4. High Cholesterol** ☐ **Yes** ☐ **No**

If yes, list 3 most recent readings:

1) 2) 3)

**5. High Blood Pressure** ☐ **Yes** ☐ **No**

If yes, list 3 most recent readings:

1) 2) 3)

| | Yes | No |
|---|---|---|
| **6. Arthritis** (i.e. rheumatoid, osteo, psoriatic, gout) | ☐ | ☐ |
| **7. Autoimmune Disease** (i.e. lupus, MS, anemia) | ☐ | ☐ |
| **8. Back Disorder** (i.e. degenerative disk disease, herniated disk, spinal fusion, spondylitis, strain) | ☐ | ☐ |
| **9. Benign Growth** (i.e. tumor, cyst) | ☐ | ☐ |
| **10. Bowel** (i.e. irritable bowel IBS, Crohn's ileitis) | ☐ | ☐ |
| **11. Circulatory System Disease** (i.e. stroke, arterial / vascular diseases) | ☐ | ☐ |
| **12. Immunodeficiency** (i.e. AIDS, HIV+, hemophilia) | ☐ | ☐ |
| **13. Kidney Disorder** (i.e. nephritis, renal failure) | ☐ | ☐ |
| **14. Liver Disease** (i.e. cirrhosis, hepatitis A, B, C, E) | ☐ | ☐ |
| **15. Mental Illness** (i.e. mild or major depression, anxiety, bipolar disorder, or schizophrenia) | ☐ | ☐ |
| **16. Counseling** Current or prior counseling? | ☐ | ☐ |
| **17. Muscular Disorder** | ☐ | ☐ |
| **18. Respiratory** (i.e. asthma, allergies, pneumonia, COPD, emphysema, bronchitis) | ☐ | ☐ |
| **19. Stomach** (i.e. ulcer, acid reflux, GERD) | ☐ | ☐ |
| **20. Substance dependency** (i.e. alcohol, drug) | ☐ | ☐ |
| **21. Transplants** (if yes, list organ(s): _____ ) | ☐ | ☐ |

## II. Medical Conditions & Treatments (continued)

| | Yes | No |
|---|---|---|
| **22.** Is anyone currently taking **prescription medication(s)**?..... | ☐ | ☐ |
| **23.** Has anyone had any of the following for a **serious illness** in the past 5 years? | | |
| a) treatment…… | ☐ | ☐ |
| b) hospitalization…… | ☐ | ☐ |
| c) surgery…… | ☐ | ☐ |
| **24.** Is anyone **currently**: | | |
| a) hospitalized or confined in a treatment facility?…… | ☐ | ☐ |
| b) confined at home, incapacitated or incapable of self-support?…… | ☐ | ☐ |
| **25.** Is any of the following **pending**? | | |
| a) treatment (medical treatment or diagnostic testing)…… | ☐ | ☐ |
| b) hospitalization…… | ☐ | ☐ |
| c) surgery…… | ☐ | ☐ |
| **26.** In the past 5 years, has anyone enrolling had **symptoms** of any serious medical condition not yet indicated on this form?..... | ☐ | ☐ |

**Reminder:**
Please complete
ADDITIONAL DETAIL TABLE
for **ALL** items answered "YES"
on Pages 1 & 2

## III. Pregnancy and Childbirth

| | Yes | No |
|---|---|---|
| **27.** Is anyone **pregnant?** (If no, mark "No" and skip question 27.)…… | ☐ | ☐ |
| 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 ☐ **twins** ☐ **triplets** ☐ **more**

## ADDITIONAL DETAIL TABLE - Please Fill In Details Below For All Questions Answered "YES"

| Question # | Name of Individual | Condition / Diagnosis | Date of Onset | Last Date Treated | Treatment / Drug | Still taking? ( Y / N ) | Degree of Recovery |
|---|---|---|---|---|---|---|---|
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*** If you marked "Yes" to any item on Pages 1 & 2, please complete ADDITIONAL DETAIL TABLE above, or this form will not be accepted.**

### Income Verification

This section of the application will only be used for the purpose of determining eligibility for patient assistance programs which are designed to provide you with low cost or no cost medications. Participation may also save you money on copayments and/or deductibles. Please indicate the range of your household annual income.

☐ $25K-$50K ☐ $50K-$75K ☐ $75K-$100K ☐ $100K-$150K ☐ $150-$200 ☐ $200K +

In the event that information submitted on this form constitutes fraud or there is an intentional misrepresentation of the material fact, the plan may rescind coverage, foreither the individual or the entire group. In any such case, I understand that the plan will return any contributions that have previously been paid as to the rescinded coverage. I certify that the statements 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.

Triad gathers this information for statistical and actuarial use only. This information is not to be used in connection with any decisions or actions regarding any individual's employment. Prospective employees in Michigan should not provide information regarding height or weight. In compliance with requirements for GINA, Triad is not requesting genetic information.

Triad Program Notice of Privacy Practices provides more detailed information about how Triad Program and the health plan I have chosen may use and disclose my protected health information. I have a legal right to review this Notice of Privacy practices before I sign this consent and I am encouraged to read it in full. Ihave a right to request restrictions on how my protected health information is used and disclosed. The Triad Program and my health plan are not required by law to grant my request. However, if my request is granted, the Triad Program and my health plan are bound by their agreement. I have a right to revoke this consent in writing, except to the extent the Triad Program or my health plan have already used or disclosed my protected health information in reliance upon my consent. I will notify Triad of any health or enrollment related changes that occur after signing this form up to the effective date of coverage on the health plan.

By signing this PHQ, I acknowledge that I am self-employed and upon approval and payment of premium, I will automatically become a passive, non-voting certificate class member of Triad Benefits, LLC. This certificate of membership will remain in force for a long as I continue to participate in or benefits offered through Triad Benefits, LLC. I further understand that while I have certificate membership in Triad Benefits, LLC., that affords me no managerial status, voting rights or rights to profits or liabilities. I grant full managerial duties to the duly appointed managers of Triad Benefits LLC., a manager-managed LLC. Additionally, by becoming a Certificate Member, I acknowledge that I will only have access to consulting services and products specifically designed for Triad Benefits, LLC. members. Member understands and agrees the Plan may modify health care fees or be terminated based on Member's experience and/or utilization. Any such modification or termination must be presented to the member 60 days prior to the members renewal date.

Employee SIGN Here and Date:

_____ Date _____

### Client Privacy Notification

Thank you for completing the requested information above. Any non-public personal health information (i.e., name with address and/or social security number and detailed health information) (protected health information) that you provide via hard copy or through this process. This application will be used be solely for the purpose of providing risk assessment to Triad that will provide a health care benefit quote to your employer. Triad's actuary and underwriter are acting as a Business Associate and are subject to certain provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations. Conquers actuary and underwriter will not sell, license, transmit or disclose this information outside of their offices except as: a) necessary for them to provide the services on behalf of the plan, b) expressly authorized by you, c) necessary for backup documentation purposes, or d) required by law.