Sam Bond Benefit Group, Inc.

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Personal Health Questionnaire (PHQ)

Employee Name:	Employer Name:
Daytime Phone: ( )	Date of Hire:

Are you planning to enroll in your employer's health insurance plan? ☐ Yes ☐ No; If you selected "No", please choose one of the following, then skip the remainder of the form and sign bottom of p. 2

☐ Covered by Spouse 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	Gender (M / F)	Date of Birth (mm/dd/yyyy)	Height ft.	Height In.	Weight (lbs)	Home Zip Code	Tobacco Use in last year (Yes / No)
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 hospitalized for any of the following?

Check "YES" or "NO" for each question. Please complete ADDITIONAL DETAIL TABLE on p. 2 for ALL "Yes" answers.

1	☐ Yes ☐ No	**Cancer** (if yes, list location and type) Location and type of cancer Check Stage: ☐ 1 ☐ 2 ☐ 3 ☐ Higher Date of remission (if applicable):
2	☐ Yes ☐ No	**Cardiac or Heart Disease / Disorder** (if yes, check all that apply) ☐ Heart Attack ☐ bypass surgery or angioplasty on single vessel ☐ bypass surgery or angioplasty on multiple vessels ☐ ANY other heart conditions (list here) (i.e. arrhythmia, aneurysm, heart failure, heart valve disorder)
3	☐ Yes ☐ No	**Diabetes** (if yes check 1 or 2) Type: ☐ 1 or ☐ 2 If Yes, list 3 most recent HbA 1c / fasting blood sugar levels: 1) 2) 3)
4	☐ Yes ☐ No	**High Cholesterol** If Yes, list 3 most recent readings: 1) 2) 3)
5	☐ Yes ☐ No	**High Blood Pressure** If Yes, list 3 most recent readings: 1) 2) 3
6	☐ Yes ☐ No	**Arthritis** (i.e. rheumatoid, osteo, psoriatic, gout)
7	☐ Yes ☐ No	**Autoimmune Disease** (i.e. lupus, MS, anemia)
8	☐ Yes ☐ No	**Back Disorder** (i.e. degenerative disk disease, herniated disk, spinal fusion, spondylitis, strain)

II. Medical Conditions & Treatments (continued)		
REMINDER: Please complete "ADDITIONAL DETAIL TABLE" for all items answered "Yes" on page 1 & 2		
9	☐ Yes ☐ No	**Benign Growth** (i.e. tumor, cyst)
10	☐ Yes ☐ No	**Bowel** (i.e. irritable bowel IBS, Crohn's iletis)
11	☐ Yes ☐ No	**Circulatory System Disease** (i.e. stroke, arterial / vascular diseases)
12	☐ Yes ☐ No	**Immunodeficiency** (i.e. AIDS, HIV+, hemophilia)
13	☐ Yes ☐ No	**Kidney Disorder** (i.e. nephritis, renal failure)
14	☐ Yes ☐ No	**Liver Disease** (i.e. cirrhosis, hepatitis, A, B, C, E)
15	☐ Yes ☐ No	**Mental Illness** (i.e. mild or major depression, anxiety, bipolar disorder, or schizophrenia)
16	☐ Yes ☐ No	**Counseling** - Current or prior counseling?
17	☐ Yes ☐ No	**Muscular Disorder**
18	☐ Yes ☐ No	**Respiratory** (i.e. asthmas, allergies, pneumonia, COPD, emphysema, bronchitis)
19	☐ Yes ☐ No	**Stomach** (i.e. ulcer, acid reflux, GERD)
20	☐ Yes ☐ No	**Substance dependency** (i.e. alcohol, drug)
21	☐ Yes ☐ No	**Transplants** (if yes list organ(s): _____)
22	☐ Yes ☐ No	Is anyone taking **prescription medication(s)?**
23	☐ Yes ☐ No	Has anyone had any of the following for a **serious illness** in the past 5 years? ☐ a) treatment ☐ b) hospitalization ☐ c) surgery
24	☐ Yes ☐ No	**Is anyone currently** ☐ a) hospitalized or confined in a treatment facility ☐ b) Confined at home, incapacitated or incapable of self-support?
25	☐ Yes ☐ No	Is any of the following **pending?** ☐ a) treatment (medical treatment or diagnostic testing) ☐ b) hospitalization ☐ c) surgery
26	☐ Yes ☐ No	In the past 5 years, has anyone enrolling had **symptoms** of any serious medical condition not yet indicated on this form?
III. Pregnancy and Childbirth		
27	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	Is anyone **pregnant?** (if no, mark "NO" and skip question 27 details) a) Due Date: _____ b) Is this a high risk pregnancy, any complication 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	Conditions / Diagnosis	Date of onset	Last Date Treated	Treatment / Drug	Still Taking? (Y / N)	Degree of Recovery

***If you marked "Yes" to any item on Page 1 or 2, please complete the above details, or this form will not be accepted.**

In the event that information has been intentionally omitted or misrepresented, the PEO and/or the insurance carrier may deny or limit coverage, In such cases, I understand that the PEO and/or the insurance carrier may change my insurance premiums. 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.

The PEO and/or the insurance carrier gathers this information to convey on behalf of prospective clients. 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, the PEO and/or the insurance carrier is not requesting genetic information.

The PEO and/or the insurance carriers' Privacy Practices Policy provides more detailed information about how the provider 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. I have a right to request restrictions on how my protected health information is used and disclosed. The PEO and/or the insurance carrier are not required by law to grant my request. However, if my request is granted, the PEO and/or the insurance carrier are bound by their agreement. I have a right to revoke this consent in writing, except to the extent the PEO and/or the insurance carrier have already used or disclosed my protected health information in reliance upon my consent. I will notify the PEO and/or the insurance carrier of any health or enrollment related changes that occur after signing this form up to the effective date of coverage on the health plan.

Employee SIGN HERE and Date:

→	**Date:**