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 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 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

*** If you marked "Yes" to any item on Pages 1 & 2, please complete ADDITIONAL DETAIL TABLE above, or this form will not be accepted.**

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, for either 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.
The Plan 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, The Plan is not requesting genetic information.
The Plan's Notice of Privacy Practices provides more detailed information about how 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. I have a right to request restrictions on how my protected health information is used and disclosed. The Plan is not required by law to grant my request. However, if my request is granted, the Plan is bound by their agreement. I have a right to revoke this consent in writing, except to the extent The Plan has already used or disclosed my protected health information in reliance upon my consent. I will notify The Plan 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:_____

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 Conquer that will provide a health care benefit quote to your employer. Conquers 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. The Plan's 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 you empoyers pllan, b) expressly authorized by you, c) necessary for backup documentation purposes, or d) required by law.