Tennessee DENTAL ASSOCIATION

Administered by:
TD Consortium Benefits Trust

TDC BENEFITS PLAN

6505 Lee Highway, Chattanooga, TN 37421
Phone: 800.347.1109 • Fax: 866.791.2806

Personal Health Questionnaire (PHQ)

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

Daytime Phone: _____ **Date of Hire:** _____

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

Employee Email: _____

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 2.

☐ 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. & 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 and 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 page 2 for ALL "Yes" answers.

1. Cancer (If yes, list location and type of cancer) — 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
☐ 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 syndrome, 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 and Treatments (Continued)

	Yes	No
22. Is anyone currently taking **prescription medication(s)**?	☐	☐
23. Has anyone had any of the following or a **serious illness** in the past 5 years?		
a) Treatment	☐	☐
b) Hospitalization	☐	☐
c) Surgery	☐	☐
24. Is anyone **currently**:		
a) hospitalized or confined to 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?	☐	☐

III. Pregnancy and Childbirth

	Yes	No
27. Is anyone **pregnant**? (If no, mark "No" and skip question 27)	☐	☐
a) Due Date:_____		
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 yes, check one:		
☐ Twins ☐ Triplets ☐ More		

REMINDER:
Please complete ADDITIONAL DETAIL TABLE for **ALL** questions answered "Yes" on Pages 1 or 2

Additional Detail Table – Please provide details 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 answered "Yes" to any question on pages 1 or 2, please complete ADDITIONAL DETAIL TABLE above or this form will not be accepted.

I acknowledge and agree that in the event that information has been intentionally omitted or misrepresented, the insurance carrier may deny or limit coverage and the THP service agreement may terminate for breach. In such cases, I understand that THP or the carrier may change my insurance premiums. 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. THP 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 GINA, THP is not requesting genetic information. THP Notice of Privacy Practices provides more detailed information about how THP 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. The THP and my health plan are not required by law to grant my request. However, if my request is granted, the THP and my health plan are bound by their agreement. I have a right to revoke this consent in writing, except to the extent the THP or my health plan have already used or disclosed my protected health information in reliance upon my consent. I will notify THP of any health or enrollment related changes that occur after signing this form up to the effective date of coverage on the health plan.

I also hereby authorize any physician, medical practitioner, hospital, clinic, Veterans administrations facility, other medical or medically related facility, insurance or reinsurance company, pharmacy, pharmacy benefit manager, health plan, or Consumer Reporting Agency, having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition, including drug or alcohol abuse, and/or treatment of me or my minor children and other non-medical information of me and my minor children, to release to the claims or third party administrator, any other excess loss insurance carrier designated by the Plan, or its legal representative, any and all such information as required for determination of eligibility for benefits. I also understand that my dependents of legal age, in order to be eligible for benefits, may be required to sign a similar release of medical records for the purpose of determining the accuracy of statements made by me on this form and for the ultimate determination of eligibility for benefits under the Plan. I understand that I may request a copy of this authorization at any time. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I agree that a photographic copy of this authorization shall be as valid as the original, and that this authorization shall be valid for 2 ½ years from the date shown below. I understand the information obtained by use of this authorization may be used by the Plan Sponsor, claims or third party administrator, and any excess loss insurance carrier designated by the Plan to determine eligibility for coverage. Any information obtained will not be released to any person or organization, except to reinsuring companies or other persons or organizations performing business or legal services in connection with my enrollment for the coverage, for any claim, for medical management purposes, or as may be otherwise lawfully required or as I may further authorize. I also understand that I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization. Should I refuse to sign this authorization, I understand it may affect my enrollment in the benefit plan. All pages must be attached and complete, including this authorization for the statement to be considered complete. Incomplete statements may be rejected.

Employee Signature:_____ 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 solely for the purpose of providing risk assessment to the Professional Employer Organization (PEO), Multiple Employer Welfare Arrangement (MEWA), association group (Association) that will provide a health insurance quote to your employer. Strategic Underwriting Solutions, LLC is acting as a Business Associate to the PEO / MEWA / Association / Trust and is subject to certain provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations. Strategic Underwriting Solutions, LLC will not sell, license, transmit or disclose this information outside of Strategic Underwriting Solutions, LLC except as: a) necessary for Strategic Underwriting Solutions, LLC to provide the services on behalf of the PEO MEWA/Association /Trust, b) expressly authorized by you, c) necessary for backup documentation purposes, or d) required by law.