

## Personal Health Questionnaire (PHQ)

Employee Name:					Employer Name:						
Daytime Phone: ( ) -					Date of Hire:						
Are	you plannin	g to enroll in	your employer's	s health insu	urance p	lan?	<b>-</b> 1	′es □ No			
<u>*** If</u>	you selected	"No", please se		pouse's pla	kip the re	☐ Not E	ligible	d sign the botton		)	
· Ans · Inci · All	swer the followii lude additional s questions must	ng questions for sheets for detaile be answered or	mplete the rest of the rest of the repeat of the rest of the rest of the rest of the rest of the form may not be	enrolling famil dditional depen		rs.					
I. D	emograpnic,	Build and To	obacco Use		1					ı	
	Relation to Employee	Member Name		Gender (M/F)		of Birth dd/yyyy)	Heigi	ht Weight (lbs)	Home Zip Code	Tobacco use in last year? (Yes / No)	
1	Employee										
2	Spouse										
3	Child										
4	Child										
5	Child										
6	Child										
			itments ve seen a medical	provider, ha	d treatme	ent recomn	nended, re	ceived care (inc	luding presci	riptions)	
	Has any pers or been hosp Check "YES	son listed above otialized for an S" or "NO" fo	ve seen a medical ny of the following r each question.	? Please con	nplete A			-		es" answers.	
	Has any person been hosp Check "YES	son listed above otialized for an 5" or "NO" for s, list location and	ve seen a medical ny of the following r each question.	? Please con		DDITIONA	L DETAIL	. TABLE on p. 2	2 for <u>ALL</u> "Y		
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II. Medi	cal Conditions & Tre	atments (continued)		Yes	No			
<b>22.</b> Is a	nyone currently taking <b>p</b> o	rescription medication(s)?.						
<b>23.</b> Has	anyone had any of the	following for a serious illnes	<b>s</b> in the past 5	years?			Remind	
a) tr	eatment						Please com DITIONAL	
b) h	ospitalization					AD	TABLE	
c) sı	urgery					for A	ALL items a	
<b>24.</b> Is a	nyone <b>currently</b> :						"YES"	
a) h	ospitalized or confined in	a treatment facility?					on Pages	1 & 2
b) c	onfined at home, incapa	citated or incapable of self-su	ipport?					
<b>25.</b> Is a	ny of the following pend	ing?						
a) tr	eatment (medical treatm	ent or diagnostic testing)						
,	•							
<b>26.</b> In th	ne past 5 vears, has any	one enrolling had <b>symptoms</b>	of anv serious	s				
		licated on this form?						
	, ,							
III. Pred	gnancy and Childbi	rth		Yes	No			
	-	, mark "No" and skip question	n 27 )					
	he due date is:	, mant the and only quodion						
		ancy, any complications or ble	eding?					
,	•	term birth?	•					
	· · · · · · · · · · · · · · · · · · ·	ed? If so, please check one:						
u) A	ile multiple biltilis expect	eu : II so, piease check one.	twins _	tripletsmo	ore			
ADDITI	ONAL DETAIL TAR	LE - Please Fill In Deta	ils Balow F	or All Question	e Anewara	1 "VEC"		
		LL - I icase i ili ili Deta		T T			Still	Degree of
Question #	Name of Individual	Condition / Diagnosis	Date of Onset	Last Date Treated	Treatmen	t / Drug	taking?	Recovery
							(Y/N)	
*_	<u>lf you marked "Y</u>	<u>es"</u> to any item on P				ITIONA	<u>L DETAIL</u>	TABLE
		above, or t	<u>his form w</u>	vill not be acc	epted.			
		ntionally omitted or misrepresented,						
		uch cases, I understand that Advanta I understand that this form is used for				nce premiums	. I certify that th	e statements are tru
		and actuarial use only. This informa			•	tions regarding	g any individual's	s employment. In
		dvantage Health Plans Trust is not r			ny decisione er de	nono rogaram	g any marviadare	omploymont. III
My healthca	are provider's notice of privacy	practices provides more detailed inf	ormation about ho	w my protected health in	nformation is discl	osed. I have a	a legal right to re	view a notice of
		.t and I am encouraged to read it in fund my health plan are not required by						
my health p	olan are bound by their agreem	ent. I have a right to revoke this con	sent in writing, exc	cept to the extent the Ad	vantage Health P	lans Trust Pro	gram or my heal	th plan have already
	closed my protected health info to the effective date of covera	ormation in reliance upon my consen- age on the health plan.	t. I will notify Adva	antage Health Plans Tru	st of any health or	enrollment re	lated changes th	nat occur after signin
		·						
Emb	loyee SIGN HERE and Date	ē.						
			Date:					

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