Personal Health Questionnaire (PHQ) *(1 of 2)*

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 select one of the following:

☐ Covered by Spouse's plan ☐ Not Eligible ☐ Do Not Want Coverage ☐ Other Reason_____

If you have selected "Yes," please complete the rest of the form. If you have selected "No," skip the remainder and sign at the bottom.

- Please answer the following questions for yourself and eligible enrolling family members.
- You may include additional sheets for detailed explanations or additional dependents.
- All of the questions must be answered or the form may be returned.
- Incomplete forms may delay the effective date of coverage.

I. Demographic, Build and Tobacco Use

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

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 page 2 for ALL "Yes" answers.

1. Cancer: (If yes, 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, or
   ☐ bypass surgery or angioplasty on multiple vessels;
   ☐ ANY other heart conditions (list here): _____
   _____
   (e.g., arrhythmia, aneurysm, heart failure, heart valve disorder)

3. Diabetes: (If yes, list type 1 or 2)..... ☐ Yes ☐ No
   ☐ Type 1 ☐ Type 2
   If yes, list 3 most recent HbA1c / fasting blood sugar levels:
   1)_____ 2)_____ 3)_____

4. High Cholesterol: (If yes, 3 most recent readings)
   1)_____ 2)_____ 3)_____ ☐ Yes ☐ No

5. High Blood Pressure: (If yes, 3 most recent readings)
   1)_____ 2)_____ 3)_____ ☐ Yes ☐ No

6. Arthritis: (e.g., rheumatoid, osteo, psoriatic, gout) ☐ Yes ☐ No

7. Autoimmune Disease: (e.g., lupus, MS, anemia) .. ☐ Yes ☐ No

8. Back Disorder: (e.g., degenerative disk disease, herniated disk, spinal fusion, spondylitis, strain) ..... ☐ Yes ☐ No

9. Benign Growth: (e.g., tumor, cyst) ..... ☐ Yes ☐ No

10. Bowel: (e.g., irritable bowel/IBS, Crohn's ileitis). ☐ Yes ☐ No

11. Circulatory System Disease: (e.g., stroke, arterial/vascular diseases..... ☐ Yes ☐ No

12. Immunodeficiency: (e.g., AIDS, hemophilia)..... ☐ Yes ☐ No

13. Kidney Disorder: (e.g., nephritis, renal failure)... ☐ Yes ☐ No

14. Liver Disease: (e.g., cirrhosis, hepatitis A, B, C, E) ☐ Yes ☐ No

15. Mental Illness: (e.g., mild or major depression, anxiety, bipolar disorder, schizophrenia) ..... ☐ Yes ☐ No

16. Counseling: (either current or prior)..... ☐ Yes ☐ No

17. Muscular Disorder: ..... ☐ Yes ☐ No

18. Respiratory: (e.g., asthma, allergies, pneumonia, COPD, emphysema, bronchitis) ..... ☐ Yes ☐ No

19. Stomach: (e.g., ulcer, acid reflux, GERD) ..... ☐ Yes ☐ No

20. Substance dependency: (e.g., alcohol, drug).... ☐ Yes ☐ No

21. Transplants: (If yes, list organ(s) below)..... ☐ Yes ☐ No

_____

Personal Health Questionnaire *(2 of 2)*

II. Medical Conditions & Treatments (continued)

22. Is anyone currently taking prescription medication(s)? ..... ◯ Yes ◯ No

23. Has anyone had any of the following for a serious illness in the past five years?

a) treatment:..... ◯ Yes ◯ No

b) hospitalization: ..... ◯ Yes ◯ No

c) surgery:..... ◯ Yes ◯ No

24. Is anyone currently:

a) hospitalized or confined in a treatment facility?..... ◯ Yes ◯ No

b) confined at home, incapacitated or incapable of self-support? ..... ◯ Yes ◯ No

25. Are any of the following pending?

a) treatment (medical treatment or diagnostic testing):..... ◯ Yes ◯ No

b) hospitalization: ..... ◯ Yes ◯ No

c) surgery:..... ◯ Yes ◯ No

26. In the past five years, has anyone enrolling had symptoms of any serious medical condition not yet indicated on this form?..... ◯ Yes ◯ No

III. Pregnancy and Childbirth

27. Is anyone pregnant? ..... Yes No

(If no, mark "No" and skip the rest of question 27)

a) The due date is:_____

b) Is this a High Risk Pregnancy, any complications or bleeding?..... ◯ Yes ◯ No

c) Previous c-section or pre-term birth?..... ◯ Yes ◯ No

d) Are multiple births expected? If so, please check one:

☐ Twins ☐ Triplets ☐ More

*If you marked "Yes" for any responses in Sections II or III, please complete ADDITIONAL DETAIL TABLE below, or this form will not be accepted.

Question #	Name	Condition / Diagnosis	Date of Onset	Last Date Treated	Treatment/Drug	Still taking?	Degree of Recovery
						◯ Yes ◯ No	
						◯ Yes ◯ No	
						◯ Yes ◯ No	
						◯ Yes ◯ No	
						◯ Yes ◯ No	
						◯ Yes ◯ No	
						◯ Yes ◯ No	

This information is gathered so that PeakAdvisors Inc, its actuaries, and its insurers can perform actuarial and other analyses of your group, which is considering participating in certain PEO group benefit plans. By signing this form you consent to such use, and your consent will remain effective unless and until revoked. Signing this form does not enroll you in a PEO benefit plan, nor is it a condition of treatment, payment, enrollment, or eligibility under PEO benefit plans. The individual PEO's Notice of Privacy Practices provides more detailed information about how your protected health information may be used under privacy laws, and you consent to such uses. You have the right to review the Notice of Privacy Practices before signing this form. Peak Advisors and any PEO will treat your information in accordance with this consent and the Notice of Privacy Practices, but once your information has been disclosed to others it may no longer be protected by privacy laws. You may revoke your consent at any time; revocation will be effective as of the date received in writing by the PEO's benefits department and will not apply to information that has already been used or disclosed in reliance on your previous consent. PeakAdvisors Inc will provide you a copy of this form as signed by you on your written request.

By signing below you certify that: you have given your consent voluntarily; you understand that PeakAdvisors Inc and its insurers and actuaries will rely on the information you provide; and the information you provide on this form is true and complete to the best of your knowledge (however, persons employed in Michigan should omit information about height and weight). You also agree to immediately notify PeakAdvisors Inc in writing of any changes to the information you provide on this form that you become aware of between your submission of this form and the date upon which you become covered by any PEO benefit plan. If you knowingly make any misrepresentations or omissions on this form, or in updating or failing to update the information on this form, it could result in denial of claims, changes in coverage terms and premium, and/or cancellation or rescission of all coverage Under any selected PEO benefit plan.

Employee SIGN HERE: _____ Date:_____