ODA
Wellness Trust

Personal Health Questionnaire (PHQ)

Employee Information:				Employer Name:
Title	First	MI	Last	
Email address:				Date of Hire:
Daytime Phone #: ( )				Marital Status: (circle one) Married Divorced Separated Single
HOME - Street Address:		City:	State:	Zip:
COUNTY OF RESIDENCE:				

Are you planning to enroll in your employer's health benefit plan? **Yes** **No**

If you selected NO check one of the following, skip the remainder of the form and sign the bottom of pg 4.
Covered by Spouse's plan Not Eligible Do Not Want Coverage Other Reason _____

* **If you selected "YES", please complete the rest of this form and sign the bottom of pg 4.**
* 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 (in last year)

Primary Applicant:						
Check one: ☐ Dr ☐ Mr ☐ Ms	First:	MI:	Last:			Social Security # - -
Date of Birth / /	Gender ☐ M ☐ F	Height Ft In	Weight Lbs.	Home Zip		Tobacco Use ☐ Yes ☐ No
Spouse:						
Check one: ☐ Dr ☐ Mr ☐ Ms	First:	MI:	Last:			Social Security # - -
Date of Birth / /	Gender ☐ M ☐ F	Height Ft In	Weight Lbs.	Home Zip		Tobacco Use ☐ Yes ☐ No
Child 1:						
	First:	MI:	Last:			Social Security # - -
Date of Birth / /	Gender ☐ M ☐ F	Height Ft In	Weight Lbs.	Home Zip		Tobacco Use ☐ Yes ☐ No
Child 2:						
	First:	MI:	Last:			Social Security # - -
Date of Birth / /	Gender ☐ M ☐ F	Height Ft In	Weight Lbs.	Home Zip		Tobacco Use ☐ Yes ☐ No
Child 3:						
	First:	MI:	Last:			Social Security # - -
Date of Birth / /	Gender ☐ M ☐ F	Height Ft In	Weight Lbs.	Home Zip		Tobacco Use ☐ Yes ☐ No
Child 4:						
	First:	MI:	Last:			Social Security # - -
Date of Birth / /	Gender ☐ M ☐ F	Height Ft In	Weight Lbs.	Home Zip		Tobacco Use ☐ Yes ☐ No

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II	**Medical Conditions & Treatments**		
	Has any person listed above seen a medical provider, had a 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 pg 3 for ALL "YES" answers.	**YES**	**NO**
1	**Austism Spectrum Disorders** (Autism, Asperger's Syndrome and Pervasive Development Disorders) – **If yes, list Therapies received and frequency:** _____ _____ _____		
2	**Cancer --** If yes, list location and type of cancer below Location and type of cancer _____ **Check one:** ☐ Stage 1; ☐ Stage 2; ☐ Stage 3; ☐ higher Date of remission (if applicable) _____		
3	**Cardiac or Heart Disease / Disorder** (i.e. arrhythmia, aneurysm, heart failure, heart valve disorder) **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):** _____		
4	**Diabetes --** ☐ Type 1 OR ☐ Type 2 If yes, list 3 most recent HbA1c / fasting blood sugar levels: 1) 2) 3)		
5	**High Cholesterol --** If yes, list 3 most recent readings: 1) 2) 3)		
6	**High Blood Pressure --** If yes, list 3 most recent readings: 1) 2) 3)		
7	**Arthritis** (i.e. rheumatoid, osteo, psoriatic, gout)		
8	**Autoimmune Disease** (i.e. lupus, MS, anemia)		
9	**Back Disorder** (i.e. degenerative disk disease, herniated disk, spinal fusion, spondylitis, strain)		
10	**Benign Growth** (i.e. tumor, cyst) location: _____		
11	**Muscular Disorder**		
12	**Bowel & Digestive Disorders** (i.e. colitis, regional enteritis, calculus of gallbladder)		
13	**Circulatory System Disease** (i.e. stroke, arterial / vascular diseases)		
14	**Immunodeficiency** (i.e. AIDS, HIV+, hemophilia)		
15	**Kidney Disorder** (i.e. nephritis, renal failure, dialysis)		
16	**Liver disease** (i.e. cirrhosis, hepatitis, A, B, C, E)		
17	**Mental Illness** (i.e. mild or major depression, anxiety, bipolar disorder, or schizophrenia)		
18	**Counseling** (current or prior)		
19	**Respiratory** (i.e. asthma, allergies, pneumonia, COPD, emphysema, bronchitis)		
20	**Stomach** (i.e. ulcer, acid reflex, GERD)		
21	**Substance dependency** (i.e. alcohol, drug)		
22	**Transplants --** If yes, list organ(s) _____		
23	**Endocrine & Metabolic Disorders** (i.e. dwarfism, cystic fibrosis, lipidosis, amyloidosis)		
24	**Congenital Abnormalities or Newborn Complications** (i.e. cleft lip or pallet, heart anomalies, down's syndrome, spina bifida, muscular dystrophy)		

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II.	Medical Conditions & Treatments (continued)	YES	NO
25	**Intracranial, Spinal Cord or Paralysis Injuries or Disorders**		
26	**Major Trauma, Amputation or Burns**		
27	**Is anyone currently taking prescription medication(s)?**		
28	**Has anyone had any of the following for a serious illness in the past 5 years?**		
	a) Treatment.....		
	b) Hospitalization.....		
	c) Surgery.....		
29	**Is anyone currently:**		
	a) Hospitalized or confined in a treatment facility?		
	b) Confined at home, incapacitated or incapable of self-support?		
30	**Is any of the following pending?**		
	a) Treatment (medical treatment or diagnostic testing).....		
	b) Hospitalization.....		
	c) Surgery.....		
31	**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
32	**Is anyone pregnant? (If yes, please answer a, b, c, d below)**		
	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: ☐ 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 2 and 3, please complete ADDITIONAL DETAIL TABLE above or this form will not be accepted.**

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

Employee SIGN HERE AND Date:

➢_____ Date _____

FRAUD STATEMENT – Any person with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

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 the Lewis & Ellis , Inc. Online Data Collection Website will be used solely for the purpose of providing risk assessment to the Professional Employer Organization (PEO), Multiple Employer Welfare Agreement (MEWA) association group (Association) that will provide a health benefits quote to your employer. Lewis & Ellis 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. Lewis & Ellis will not sell, license. Transmit or disclose this information outside of Lewis & Ellis except as a) necessary for Lewis & Ellis 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.

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Existing ODAWT Group #: _____

Dentist Name: _____

_____ Minimum # hours required per week to be eligible*

_____ Probationary Period*

_____ Employer Contribution*

Employee Name: _____

Date of Hire: _____

Eligibility Date: _____

If beyond eligibility date, a qualifying event is required.

Where have you previously been covered? _____

Provide date prior coverage ended. _____

Why did/is prior coverage end(ing)? _____

Documentation to confirm the date/reason coverage is or was terminated is required from the carrier or employer where you were previously covered.

*Per the ODAWT Participation Form on file.

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In order to qualify for medical coverage during a special enrollment period, you need to have a qualifying event. Below are examples of qualifying events and the documentation that is required to be submitted with the application.

PLEASE NOTE APPLICATIONS MUST BE SUBMITTED WITHIN ***60 DAYS*** OF THE QUALIFYING EVENT.

Family change due to:

- Marriage
  - *(copy of license)*
- Birth of a Child
  - *(change application)*
- Divorce/Legal Separation
  - *(Divorce Decree includes the date coverage terminated)*
- Adoption Placement
  - *(Adoption papers/legal guardianship papers)*
- Foster Home Placement
  - *(Legal guardianship papers)*
- Death of Spouse/Parent
  - *(Letter from employer/carrier. Must verify date terminated and caused by loss of eligible dependent status)*

Lost Coverage due to:

- Termination of Employment
- Reduction in hours worked
- Employer ceases to offer sponsored coverage

Documentation Required:
Letter from employer on company stationery and signed by company officer. Must state employee's name and verify date coverage was terminated.

Existing policy termination/renewal:

- Individual policy being terminated off-calendar year (not due to rescission or non-payment)
- Individual non-calendar year renewal

Documentation Required:
Copy of termination letter including date of termination.
OR
Copy of renewal that includes renewal effective date.

No longer eligible due to:

- Dependent Age Limit
- Income
- COBRA expiration

Documentation Required:
Letter from employer/carrier. Must state employee's name, dependents if applicable, cause of termination and date coverage was terminated.