Personal Health Questionnaire (PHQ)

Member Name*

Phone*

Email*

Address*

Oswego | Il | 60543

Occupation*

Director

- *Answer the following questions for yourself and eligible enrolling family members.*
- *All questions must be answered or the form may not be accepted.*

I. Demographic Build and Tobacco Use

Social Security Number (xxx-xx-xxxx)*

Gender*: Female

Date of Birth*: 02/17/1977

Height (ft)*: 5

Height (in)*: 9

Weight (lbs)*: 215

Zip Code*: 60543

Tobacco Use in last year?*: No

Are you adding a Spouse?*: No

Are you adding a Child?*: No

II. Medical Conditions & Treatments

Has any person listed above seen a medical provider, had treatment recommended, recieved care (including prescriptions) or been hospitalized for any of the following within the last 5 years?

Check 'YES' or 'NO' for each questions. Please complete ADDITIONAL DETAIL SECTION for ALL 'Yes' answers.

1. Cancer*

○ Yes ◉ No

2. Cardiac or Heart Disease/Disorder*

○ Yes ◉ No

3. Diabetes*

○ Yes ◉ No

4. High Cholesterol*

○ Yes ◉ No

5. High Blood Pressure*

○ Yes ◉ No

6. Arthritis (i.e. rheumatoid, osteo, psoriatic, gout)*

○ Yes ◉ No

7. Autoimmune Disease (i.e. lupus, MS, anemia)*

○ Yes ◉ No

8. Back Disorder (i.e. degenerative disk disease, herniated disk, spinal fusion, spondylitis, strain)*

○ Yes ◉ No

9. Benign Growth (i.e. tumor, cyst)*

○ Yes ◉ No

10. Bowel (i.e. irritable bowel IBS, Crohn's ileitis)*

○ Yes ◉ No

11. Circulatory System Disease (i.e. stroke, arterial / vascular diseases)*

○ Yes ◉ No

12. Immunodeficiency (i.e. AIDS, HIV+, hemophilia)*

○ Yes ◉ No

13. Kidney Disorder (i.e. nephritis, renal failure)*

○ Yes ◉ No

14. Liver Disease (i.e. cirrhosis, hepatitis A, B, C, E)*

○ Yes ◉ No

15. Mental Illness (i.e. mild or major depression, anxiety, bipolar disorder, or schizophrenia)*

○ Yes ◉ No

16. Counseling (Current or prior counseling?)*

○ Yes ◉ No

17. Muscular Disorder*

◉ Yes ○ No

18. Respiratory (i.e. asthma, allergies, pneumonia, COPD, emphysema, bronchitis)*

○ Yes ◉ No

19. Stomach (i.e. ulcer, acid reflux, GERD)*

◉ Yes ○ No

20. Substance dependency (i.e. alcohol, drug)*

○ Yes ◉ No

21. Transplants*

○ Yes ◉ No

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 5 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. Is 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 5 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

Additional Details

Please answer the following questions below for ALL above questions answered 'YES'

Question #17: Muscular Disorder

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Name of individual*

Stephanie

Condition/Diagnosis*

Cervicalgia

Date of Onset*

03/02/2020

Last Treated Date*

05/06/2020

Treatment/Drug*

Chiropractic / therapy/ Baclofen

Still taking?*

- (•) Yes
- ( ) No

Degree of Recovery*

70%

Question #19: Stomach

Question #19: Stomach

Name of individual*

Stephanie

Condition/Diagnosis*

Barrett's Disease

Date of Onset*

03/01/2018

Last Treated Date*

11/16/2019

Treatment/Drug*

Dexilant

Still taking?*

(•) Yes ( ) No

Degree of Recovery*

100%

Question #22: Prescription Medication (1)

Question #22: Prescription Medication (1)

Name of individual*

Stephanie

Condition/Diagnosis*

Migraine

Date of Onset*

12/03/1979

Last Treated Date*

04/07/2020

Treatment/Drug*

Botox Injections

Still taking?*

(•) Yes ( ) No

Degree of Recovery*

85%

Are you taking any more medications?*

( ) Yes (•) No

Question #23c: SURGERY for a serious illness in last 5 years

Question #23c: SURGERY for a serious illness in last 5 years

Name of individual*

Stephanie

Condition/Diagnosis*

Ruptured Tendon

Date of Onset*

09/07/2018

Last Treated Date*

03/15/2019

Treatment/Drug*

Surgery

Still taking?*

- ○ Yes
- ◉ No

Degree of Recovery*

100%

PHI Disclosure

By signing this application, I understand the following: That if any information submitted on this form constitutes fraud or there is an intentional misrepresentation of the material fact, the plan may rescind healthcare coverage. In any such case, I understand that the plan will return any contributions that have previously been paid as to the rescinded coverage, minus claims paid. I certify that the statements are true and correct to the best of my knowledge. I understand that this form is used for information purposes only and does not bind coverage. I understand the Conquer Benefits gathers this information for statistical and actuarial uses only and it will not be used in connection with decisions or actions regarding employment. That if I am a resident in Michigan, I do not have to provide information regarding height or weight, and that this in compliance with requirements for GINA. That I have read the **Client Privacy Notification** provided to me in this application. That as a prospective member, I have the right to request restrictions on how my protected health information is used, and that the Conquer Benefits is not required by law to grant this request, but if the request is granted, the Conquer Benefits is bound by this agreement. I also understand that I have the right to revoke this consent in writing, except to the extent the Conquer Benefits has already used or disclosed the protected health information in reliance upon my consent. I further understand that the Conquer Benefits will notify me the member of any health or enrollment related changes that occur after signing this form, up to the effective date of coverage. By signing this PHQ, I acknowledge that upon approval and payment of premium, I will automatically become a passive, non-voting certificate class member of IHA Services, LLC., a Manager Managed, LLC. This certificate of membership will remain in force for a long as I continue to participate in services or benefits offered through IHA Services, LLC. I further understand that while I have certificate membership in IHA Services, LLC., that affords me no managerial status, voting rights or rights to profits or liabilities. I grant full managerial duties to the duly appointed managers of IHA Services, LLC., a manager managed LLC. Additionally, by becoming a Certificate Member, I acknowledge that I will only have access to consulting services and products specifically designed for IHA Services, LLC. members.

Client Privacy Notification

Thank you for completing the requested information. Any information, including non-public personal health information, such as name, address and social security number, including detailed protected health information provided will be used for the sole purpose of providing a risk assessment to the health plan that will provide a health care benefit quote to your employer. The Conquer Benefits' actuary is a legally contracted underwriter acting as a Business Associate to the Conquer Benefits and is subject to certain provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations. The Conquer Benefits' 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 Conquer Benefits, b) expressly authorized by you, c) necessary for backup documentation purposes, or d) required by law.

Member SIGN HERE:*

Signature Date*

05/09/2020

Agent First Name

Agent Last Name

Medical Plan Selected: x *

- (●) 3500 Classic
- ( ) 5000 Classic
- ( ) 5000 HSA
- ( ) 7350 Value

Coverage Tier Selected: x *

- (•) Member Only
- ( ) Member and Spouse
- ( ) Member and Child(ren)
- ( ) Member and Family

Requested Effective Date^*

05/09/2020

Once you have submitted your form, please close this window to continue.

Thank you!

Form ID: S8-NGHA