



Completing Personal Health Questionnaire (PHQ)

Procedure: Below find instructions on how the Employer will complete the online Personal Health Questionnaire (PHQ).

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Completing the PHQ

Group Benefit Services, Inc. (GBS) utilizes the HERO System by Milliman to evaluate a group based on their personal health questionnaires. We ask employees to complete a Personal Health Questionnaire (PHQ) as a way to evaluate the medical risk of an employee and their dependents.

Link

Your employer will email you a link from the HERO System. In the email that your consultant there are instructions and a brief overview of why you are completing the PHQ.

123 Testing - Group Benefit Services - Personal (PHQ) Health Questionnaire

PHQ: <https://gbs.herouw.com/Forms/Index?cid=%2fe75PNMctxE%3d&isghq=false&cn=>

Thank you for choosing to complete the following health insurance questionnaire.

Your response is completely private and secure and it will help you and your employer obtain group health coverage through Group Benefit Services Health Plans.

Please make sure you have the following information available for you and your family, including:

Details about past and present health conditions, including diagnoses and outcome.

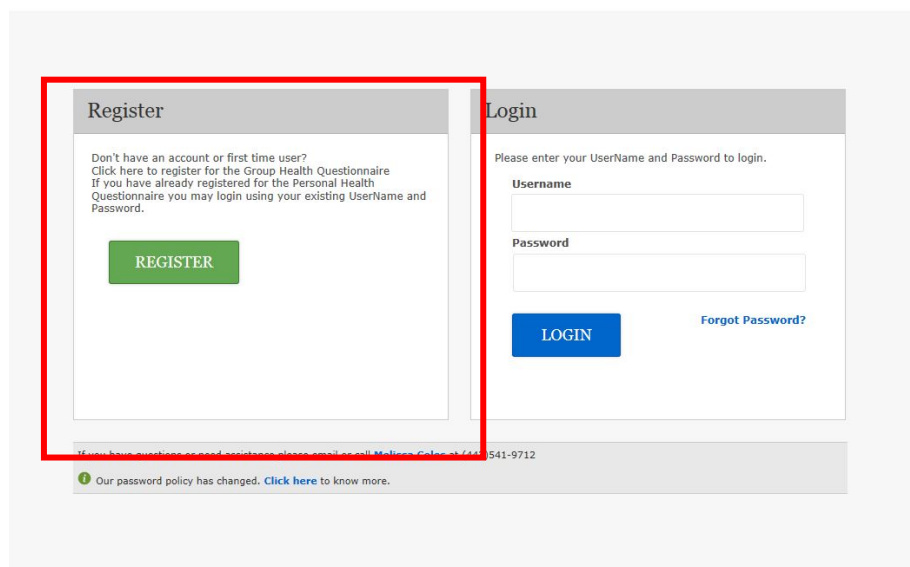
Names and dosages of all current prescriptions.

Height, weight, birth date and knowledge of tobacco usage.

Dependent social security number

Register

Click on the link for the PHQ. The screen you come to says Register or Login. Since this is your first time entering information into the system, you will need to register for an account. If at any time during the process you need to "Save and Exit" you simply click back on the link and enter the username and password that you created when you registered. If you forget your password, click on the "Forgot Password" link.



Welcome

The first screen you get to after Register, is Welcome! This is where you set your username and password. It is a good idea to write down your username and password in the event that you can't complete the entire questionnaire at one time and have to log back in.



Thank you for choosing to complete the following health insurance questionnaire.

Your response is completely private and secure and it will help you and your employer obtain group health coverage through Group Benefit Services Health Plans.

Please make sure you have the following information available for you and your family, including:

- ✓ Details about past and present health conditions, including diagnoses and outcome.
- ✓ Names and dosages of all current prescriptions.
- ✓ Height, weight, birth date and knowledge of tobacco usage.

Tips for filling out the form:

- If a medication is being taken, make sure you also choose the appropriate condition it treats and give specifics about your condition. Medications often are used to treat more than one condition. It is very important that a diagnosis is listed for any procedure that you have had.
 - If you had a procedure performed, please indicate what condition that procedure was meant to treat.
 - If you do not recall an exact date, please indicate an approximate date rather than leaving it blank.
- The questionnaire should take about 15-20 minutes.

If you have any questions or need assistance please email [Melissa Lechert](#) or call at (555)222-3333 for assistance. For technical support, please email herouw@milliman.com

EXIT

START

Completing the PHQ

The next series of screens are to show you the questions and information that you will be required to complete/answer.

Personal Health Questionnaire [User Guide](#) | [FAQ](#)

1. Identification 2. Demographic, Build and Tobacco Use 3. Medical Conditions and Treatments 4. Condition Details and Medications 5. Signature and Submission

Employee Information

*First Name

*Last Name

Suffix

*Daytime Phone

*Date of hire

*Number of dependents (excluding yourself)

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

Enrolling or Waiving

If you select “No” to the question “Are you planning to enroll?”, you will go to a waiver screen. Once you hit “Next” you will skip all of the other questions and go to the E-Signature page where you will sign and complete your waiver.

Personal Health Questionnaire [User Guide](#) | [FAQ](#)

1. Identification 2. Demographic, Build and Tobacco Use 3. Medical Conditions and Treatments 4. Condition Details and Medications 5. Signature and Submission

Employee Information

*First Name

*Last Name

Suffix

*Daytime Phone

*Date of hire

*Number of dependents (excluding yourself)

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

*Why are you not planning to enroll in your employer's health insurance plan?

- Covered by spouse's plan (copy of id card may be required)
- Not eligible (part time, seasonal, etc.)
- Do not want coverage
- I am currently in waiting period
- I am covered under another plan
- Other Reason

If you select “Yes” to the question “Are you planning to enroll?”, you will continue the process by creating a username and password and answering your medical questions before e-signing and submitting.

The screens below will walk you through those steps.

Employee Information

*First Name: Jackson

*Last Name: Lewis

Suffix:

*Daytime Phone: (444)222-3333

*Date of hire: 05/06/2010

*Number of dependents (excluding yourself): 0

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

*User Name: jacksonlewis

Password must be 8 characters in length have at least 1 capital letter, at least 1 special character and 1 numeric character

*Password: ●●●●●●●●

*Retype Password: ●●●●●●●●

*Date of birth: 02/02/1989

*Email: jackson@testing.com

*Address1: 111 south test street

Address2:

*City: Baltimore

*State: MARYLAND

*Zip Code: 21234

SAVE & EXIT NEXT >

1. Identification 2. Demographic, Build and Tobacco Use 3. Medical Conditions and Treatments 4. Condition Details and Medications 5. Signature and Submission

Family Members Information

Please include all immediate family members that will be covered with you on this plan. We request the same level of detailed health information for these individuals as for you. Click the 'Add Another' button to add more lines if necessary. All fields are required. Eligible family members include spouse, natural child, stepchild, adopted child, child placed for adoption, and child for whom you are appointed as legal guardian by the court. To be eligible for coverage, children must be under the age of 26.

*Name of individual	*SSN	*Type of relationship	*Gender	*Date of birth	*Height (ft. in)	*Weight (lbs)	*Home zip code	Tobacco use in last year
Jackson Lewis		Employee	Selec	01/08/1981	-		21234	<input type="checkbox"/> Yes

ADD ANOTHER

< PREVIOUS SAVE & EXIT NEXT >

Medical Questions

Medical Conditions and Treatments

Has any person from your listed family members seen a medical provider, had treatment recommended, received care (including prescriptions) or been hospitalized for:

1. Cancer	<input type="radio"/> Yes <input type="radio"/> No
2. Cardiac or heart disease / disorder	<input type="radio"/> Yes <input type="radio"/> No
3. Diabetes	<input type="radio"/> Yes <input type="radio"/> No
4. High Cholesterol	<input type="radio"/> Yes <input type="radio"/> No
5. High blood pressure	<input type="radio"/> Yes <input type="radio"/> No
6. AIDS or HIV+	<input type="radio"/> Yes <input type="radio"/> No
7. Arthritis (e.g. rheumatoid, osteo, psoriatic, gout)	<input type="radio"/> Yes <input type="radio"/> No
8. Back disorder (e.g. degenerative disk disease, herniated disk, spinal fusion, spondylitis, strain)	<input type="radio"/> Yes <input type="radio"/> No
9. Benign growth (e.g. tumor, cyst)	<input type="radio"/> Yes <input type="radio"/> No
10. Birth Defects	<input type="radio"/> Yes <input type="radio"/> No
11. Bowel (e.g. ulcers, hernias, chronic diarrhea, diverticulitis, diverticulosis, irritable bowel syndrome, reflux, gastroesophageal reflux disease GERD, gallbladder disorder, hemorrhoids, polyps, Crohn's disease, colitis, colostomy, ileostomy, or other digestive disorder)	<input type="radio"/> Yes <input type="radio"/> No
12. Circulatory system disease	<input type="radio"/> Yes <input type="radio"/> No
13. Immune / autoimmune disease	<input type="radio"/> Yes <input type="radio"/> No
14. Kidney disorder (e.g. nephritis, renal failure)	<input type="radio"/> Yes <input type="radio"/> No
15. Liver disease (e.g. cirrhosis, hepatitis A, B, C, E)	<input type="radio"/> Yes <input type="radio"/> No
16. Mental illness (e.g. mild or major depression, anxiety, bipolar disorder, or schizophrenia)	<input type="radio"/> Yes <input type="radio"/> No
17. Is counselling being currently received?	<input type="radio"/> Yes <input type="radio"/> No
18. Muscular Disorder	<input type="radio"/> Yes <input type="radio"/> No
19. Respiratory (e.g. asthma, allergies, pneumonia, COPD, emphysema, bronchitis, sleep apnea, pleurisy)	<input type="radio"/> Yes <input type="radio"/> No
20. Stomach (e.g. ulcer, acid reflux, GERD)	<input type="radio"/> Yes <input type="radio"/> No
21. Substance dependency (e.g. alcohol, drug)	<input type="radio"/> Yes <input type="radio"/> No
22. Stroke	<input type="radio"/> Yes <input type="radio"/> No
23. Transplants (if yes, list organ(s) on the next page)	<input type="radio"/> Yes <input type="radio"/> No

Has any one had any of the following for serious illness in the past 5 years?

1. Treatment	<input type="radio"/> Yes <input type="radio"/> No
2. Hospitalization	<input type="radio"/> Yes <input type="radio"/> No
3. Surgery	<input type="radio"/> Yes <input type="radio"/> No

Is anyone currently:

1. Hospitalized or confined in a treatment facility?	<input type="radio"/> Yes <input type="radio"/> No
2. Confined at home, incapacitated or incapable of self-support?	<input type="radio"/> Yes <input type="radio"/> No
3. In surgery or scheduled for surgery?	<input type="radio"/> Yes <input type="radio"/> No

Is any of the following pending?

1. Treatment (medical treatment or diagnostic testing)	<input type="radio"/> Yes <input type="radio"/> No
2. Hospitalization	<input type="radio"/> Yes <input type="radio"/> No
3. Surgery	<input type="radio"/> Yes <input type="radio"/> No

In the past 5 years, has anyone enrolling had symptoms of any serious medical condition not yet indicated on this form?

Yes No

Is anyone pregnant?

Yes No

Is anyone currently taking prescription medication(s) for any conditions not already indicated above?

Yes No

< PREVIOUS

SAVE & EXIT

NEXT >

Additional Details

If you selected “YES” to any of the medical questions or serious illness questions, you are required to complete the additional details below. If you enter a prescription and it is not in the drop down box, simply type the name of the prescription and follow it with a comma. (Ex. Lipitor,)

1. Identification2. Demographic, Build and Tobacco Use3. Medical Conditions and Treatments4. Condition Details and Medications5. Signature and Submission

Please complete the additional details for all the items marked as Yes in the previous screen.

Click the Add Another button to add lines for any additional conditions or medications taken by you or your family. You can select multiple prescription drugs if required in the “Treatment/Drugs” list.

High Cholesterol

*Member Name	List 3 most recent readings	*Treatment/Drug	Still Taking?
Jackson Lewis <input type="checkbox"/>	125 - 122 - 136	<input type="text" value="X lipitor"/>	<input type="checkbox"/> Yes

[ADD ANOTHER](#)

Other Conditions

Conditions	Name of Individual	*Condition/Diagnosis	*Date of onset	Last date treated	*Treatment/Drug	Still Taking	Degree of recovery

[ADD ANOTHER](#)

< PREVIOUSSAVE & EXITNEXT >

After you have entered all additional information and click on “Next”, you will be taken to the E-Signature and Submit page.

Please read these carefully! Once you click on “Submit” you CANNOT log back in and change your answers.

E-Signature and Submit


1. Identification 2. Demographic, Build and Tobacco Use 3. Medical Conditions and Treatments 4. Condition Details and Medications 5. Signature and Submission

Please read the Client Privacy Notification. By clicking on the Submit Form button you are electronically signing this document certifying that all information is true and correct.

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 Group Benefit Services service agreement may terminate for breach. In such cases, I understand that Group Benefit Services 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. Group Benefit Services 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, Group Benefit Services is not requesting genetic information. Group Benefit Services Notice of Privacy Practices provides more detailed information about how Group Benefit Services 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 Group Benefit Services and my health plan are not required by law to grant my request. However, if my request is granted, the Group Benefit Services and my health plan are bound by their agreement. I have a right to revoke this consent in writing, except to the extent the Group Benefit Services or my health plan have already used or disclosed my protected health information in reliance upon my consent. I will notify Group Benefit Services of any health or enrollment related changes that occur after signing this form up to the effective date of coverage on the health plan.

Employee Name **Jackson Lewis**

Electronic Signature [Click here to Certify that this information is true and correct](#)

 [Print Questionnaire in PDF](#)

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 Milliman, Inc. HERO Online Data Collection Website 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. Milliman 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. Milliman will not sell, license, transmit or disclose this information outside of Milliman except as: a) necessary for Milliman 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.

[Security](#)

If you have any questions or need assistance please email [Melissa Lechert](#) or call at (555)222-3333 for assistance

[< PREVIOUS](#) [SAVE & EXIT](#) [SUBMIT](#)

Complete!

After you click “Submit” the next screen is a “Thank You” for completing your PHQ online.

Thank You!

Your Submission has been received

If you have any further questions please email or call [Melissa Lechert](#) at (555)222-3333 for assistance.

Please close your browser window to protect your privacy.