Know Your Numbers

BIOMETRIC HEALTH SCREENING

SECTION 1: TO BE COMPLETED BY YOU (PLEASE PRINT)

Last Name

First Name (Legal Name, No Nicknames)

Birth Date (06221975)

Email Address

Preferred Phone Number (no spaces)

Please read the disclosure statement: I understand my individually identifiable information may be shared with and used by Onlife Health to populate health assessment data and to provide health management services including data aggregation for program improvement purposes. Such information will not be used for any other purpose. I understand that my individually identifiable health information will not be shared with MEABT; however MEABT will be advised of the fact of my participation in the Know Your Numbers campaign. The importance of safeguarding individually identifiable health information is recognized and all organizations involved in this screening are obligated to take reasonable steps to protect such information from unauthorized access or use.

Signature: _____ Date: _____ / _____ / _____

Biometric Health Screening Reward Requirements

Medically covered participants, spouses and dependents age 18 and older are eligible to receive points for the Biometric Health Screening.

►Screening must be completed between 07/01/2012 and 05/31/2013.

►Forms must be received by 05/31/2013. Any form received after this date will be held until the next program year.

►You must also complete the online Health Assessment in order to receive points for this screening.

Submit the completed Biometric Health Screening form by one of these methods to Health Solutions:

►Email: MEABT@healthsolutions.com

►Fax:410-356-6205

►US Mail: Health Solutions/Alternative Means, 11408 Cronridge Drive, Suite L, Owings Mills, MD 21117

Immediate electronic confirmation will be provided for email submissions. If you have questions or need additional assistance, please contact Health Solutions at 800-711-8656.

SECTION 2: TO BE COMPLETED BY YOUR PHYSICIAN (PLEASE PRINT)

Note: All information must be provided before you will receive any points.

Examination Date: ____ / ____ / _____ Height: _____ Weight: _____ lbs.

Total Cholesterol: _____mg/dl HDL: _____ Ratio Total/HDL: _____

LDL Cholesterol: _____ mg/dl Triglycerides: _____

Glucose Level: _____ mg/dl Fasting or Non-Fasting (Circle One)

Blood Pressure: _____ / _____ mm/Hg

Physician's Signature or stamp: _____

Physician's Name (please print): _____

Physician's Address: _____

Your Privacy is Protected: *MEABT never has access to your Health Screenings or Health Assessment input or results. MEABT health and wellness programs are completely confidential and administered through third-party vendors. Vendors will only provide MEABT with aggregate group data that is not identifiable to any individual.*