2026 DENSO Biometric Screening Pregnancy Waiver

HbD International

Your company provides the opportunity to participate in voluntary wellness screenings as part of your wellness incentive program. For associates who are pregnant, the requirement to complete the biometric screening is waived if you submit this form during the eligibility period (see relevant eligibility deadlines below). Please note that while the biometric screening component is waived, to receive your incentive you must still complete the Member Health Assessment (MHA) and submit this form by the required deadline.

ONLY SUBMIT THIS FORM IF YOU ARE PREGNANT AND WISH TO WAIVE YOUR REQUIREMENT TO COMPLETE A BIOMETRIC SCREENING.

To be eligible for Preferred Premiums in 2027:

- All associates hired on or before 9/30/2026 must complete & submit a biometric screening *(or this waiver*) and complete the Member Health Assessment (MHA) by 11/30/2026
Once completed, submit this form to HBD International by one of the following methods:
By fax: 1-844-206-1533 | By email: forms@hbdinternational.com | By mail: PO Box 382, Enola PA 17025
Note: If you have trouble submitting this form, please contact HBD at contactus@hbdinternational.com

Consent for Voluntary Participation and Authorization of Disclosure:

I understand that the information disclosed on this form will be treated as confidential. **I authorize my physician to release the information on this form to HBD.** While individual health information will not be shared with my employer, I understand that my health information may be used to evaluate the impact of wellness programs or be included in aggregate information or group summary data provided to my employer.

My health information may be shared within HBD in order to provide more personalized programming or coaching as a part of my participation within the wellness program. I authorize HBD to use and disclose my protected health information, including to my employer in the minimum amount of detail as necessary for incentive eligibility. This authorization relates to any information collected as part of my participation in health screenings as well as data collected through other aspects of the wellness program.

This authorization will expire at the end of the current year in which this authorization is signed. I understand I have the right to revoke this authorization at any time prior to the expiration date of the authorization, or to review and dispute my health information at any time by contacting HBD, in writing, by addressing correspondence with Attention to: Data and Privacy Officer, PO Box 382, Enola PA 17025. I understand that if I revoke this authorization (or decline to sign it), HBD may not have sufficient information to determine whether I qualify for certain incentives, however I am still able to participate in the wellness program.

Participant's Full Name (please print): _____ Date of Birth:

Signature: **Today's Date:**

DENSO location or affiliate where you are employed (Circle): DIAM DMMI DMTN DMAT DMAR DPAM DMNC

PHYSICIAN TO COMPLETE (Please print clearly)	
Date:	I attest the patient listed above is pregnant (please circle): Y / N
Physician name (print):	
Physician practice & office contact number:	

Physician Signature: **Date:**