2025 Physician Biometric Screening Form

HbD International

THIS PAGE DOES NOT NEED TO BE FAXED TO HBD. THIS IS FOR PARTICIPANT INFORMATION ONLY.

To be eligible for Preferred Premiums in 2026:

- All associates hired on or before 9/30/2025 must complete & submit both a biometric screening AND the online Member Health Assessment (MHA) survey on or before **11/30/2025**

Instructions:

- Please ensure all items for the biometric screening are completed. *For any result which cannot be completed, please provide a reason or note, otherwise the participant's screening may show as incomplete. *A1C is optional and can be left blank if not relevant.*
- Ensure the participant has been shown and understands the ***Consent and Disclosure***, and that they sign that section on the results page
- Only the results page needs to be **faxed to HBD at 844-206-1533, or emailed to forms@hbdinternational.com**
- Keep a record or copy of the date this screening is completed and a copy of the fax confirmation page
- **Remind the participant that to qualify for the incentive they must also complete the MHA.**
  If they have not already completed the MHA, please ask them to complete the MHA by either:
  - Logging in to DENSOHealthyHorizons.com (if they do not know how to log in, click "Contact" and ask for help)
  - Complete the MHA on-site with any of the Healthy Horizons health coaches
  - If they cannot do either of the above, then they can call HBD at 866-996-2155

PARTICIPANT MUST READ & UNDERSTAND THIS SECTION AND SIGN ON NEXT PAGE.

Consent for Voluntary Participation and Authorization of Disclosure:

I hereby consent to voluntarily participate in a health screening by a physician of my choice in order to participate in my employer's wellness program which will include a measurement of my Cholesterol and lipid panels, blood glucose, blood pressure, waist, height, and weight.

I understand that I may ask questions or follow up on my results directly with my practitioner.

I understand that the information collected during this screening will be treated as confidential. **I authorize my physician to release the information obtained in this screening 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 this screening 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.

Complete your MHA and view your screening results at DENSOHealthyHorizons.com or speak with a Healthy Horizons Health Coach to check your data is complete.

Healthy HORIZONS kaizen your life

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This page should be completed and sent to HBD by 11/30/2025:

By fax: 1-844-206-1533 | By email: forms@hbdinternational.com | By mail: PO Box 382, Enola PA 17025

PARTICIPANT: I have read and understand the "Consent for Voluntary Participation and Authorization of Disclosure" which accompanied this page. I know that if I have questions or wish to revoke my consent, I can do so by contacting HBD in writing at HBD International, LLC, PO Box 382, Enola PA 17025.

Participant Name (print clearly): _____ Date of Birth: _____

Signature: **Date:**

Participant: I understand that if I wish to qualify for DENSO's Preferred Premiums, it is my responsibility to ensure that this form is completed accurately and successfully submitted to, and received by HBD. I can check that my screening results have successfully been submitted by checking my screening status at DENSOHealthyHorizons.com, by asking a Healthy Horizons health coach, or by contacting HBD.

Initial here to acknowledge: _____

PROVIDER TO COMPLETE:

Please print clearly, complete all sections AND indicate fasting status for blood tests.

Blood results are: ☐ **Fasting** ☐ **Non-fasting** **Date of Appointment:** _____

Total Cholesterol (mg/DL):	HDL (mg/DL):	LDL (mg/DL):
Triglycerides (mg/DL):	Blood Glucose (mg/DL):	Blood Pressure: /
Height: (Inches)	Weight: (Pounds)	*Optional: A1C

Provider Name (print): _____

Practice name and contact information or any provider notes:

_____

_____

_____

Provider Signature: **Today's Date:**