

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

To be eligible for Preferred Premiums in 2027, the following criteria will apply to complete a biometric screening AND the online Member Health Assessment (MHA) during 2026:

- All associates hired on or before 9/30/2026 must complete & submit both items by 11/30/2026

## 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
- Ensure the participant has been shown and understands the Consent and Disclosure, and that they sign that section on the results page
- The patient information and results pages (pages 2-3) need to be sent to HBD.  
Email the completed forms to [forms@hbdinternational.com](mailto:forms@hbdinternational.com), or fax to +1 844-206-1533
- Keep a record or copy of the date this screening is completed and a copy of the fax confirmation page or email
- **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 logging into their profile at [DENSOHealthyHorizons.com](https://DENSOHealthyHorizons.com). If they are unable to login, please contact HBD at [contactus@hbdinternational.com](mailto:contactus@hbdinternational.com) for help.**

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 it is my responsibility to ask questions or follow up results directly with my practitioner and in no way hold HBD (including affiliates, employees, agents, and contractors) or my employer liable for any grievance which may arise as a result of my participation in this screening.

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.

I understand I have the right to revoke this 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 I may no longer be eligible for certain incentives, however I am still able to participate in the wellness program.

**Complete your MHA and view your screening data at [DENSOHealthyHorizons.com](https://DENSOHealthyHorizons.com)  
or speak with a Healthy Horizons Health Coach to check your data is complete.**





## Part one - PATIENT TO COMPLETE

Please print clearly and complete all sections that are not marked as optional.

First name:	Last name:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth: (MM/DD/YYYY):
Email:	Phone number ( <i>optional</i> ):
<input type="checkbox"/> Check here if you do not want to receive periodic emails with tips specific to my health needs.	

I attest that have read and understand the consent and disclosure authorization accompanying this form. I hereby consent to voluntarily participate in this screening and authorize my physician to report all results to HBD as part of my participation in my employer's wellness program and incentive program. I authorize HBD to contact my physician to validate my results, if necessary, as determined by HBD.

**Signature:**

**Date:**

## Part two - PHYSICIAN TO COMPLETE

Please print clearly and complete all sections that are not marked as optional.

Blood Pressure: 血圧	Total Cholesterol (mg/DL): 総コレステロール	HDL (mg/DL): 高比重リポタンパク (HDL)
Triglycerides: トリグリセリド	Blood Glucose (mg/DL): 血糖値 <input type="checkbox"/> Fasting 断食	<input type="checkbox"/> Non fasting 非空腹
Height: 高さ	Waist measurement: ウエストメジャー	Weight: 重量
<b>Physician name (print):</b>		
Physician Practice Name:		
Address:		Phone:
State of License:		

**Signature:**

**Date:**

医師名と診療情報をここに提供してください

Scan and email this document to: [astephenon@hbdinternational.com](mailto:astephenon@hbdinternational.com)

Fax to: (+1) 844-206-1533

Mail to: HBD International, Attn: Privacy Officer, PO Box 382, Enola PA 17025, USA