Health Solutions
assess. engage. transform

LGC
NEW HAMPSHIRE
Local Government Center

Onlife HEALTH

Know Your Numbers

BIOMETRIC HEALTH SCREENING

Receive a $25 reward for completing your 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 (optional)

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 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 NHLGC; however NHLGC will be advised of the fact of my participation. 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 enrollees and spouses are eligible to receive a $25 reward for completing their Biometric Health Screening.

►This form must be completed in its entirety and be received by Health Solutions no later than **December 15, 2012**, and

►The Biometric Health Screening must have been completed within the past 6 months, and

►The 2012 Health Assessment must be completed.

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

Email: NHLGC@healthsolutions.com
Fax: 410.356.6205
US Mail: Alternative Means, 11408 Cronridge Drive, Suite L, Owings Mills, MD 21117

Immediate electronic confirmation will be provided for email and fax 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 to receive the $25 reward.

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