Biometrics Screening Notice, Authorization and Release

The Employees' Health and Benefit Plan (the "Plan") has contracted with Premise Health Employer Solutions, LLC, on behalf of its affiliate eHealthScreenings ("eHealthScreenings") to facilitate voluntary biometric screening services for its members.

Protections from Disclosure of Medical Information: As a business associate under the Health Insurance Portability and Accountability Act ("HIPAA"), eHealthScreenings is required by law to maintain the privacy and security of your personally identifiable health information in accordance with the Plan's Notice of Privacy Practices, a copy of which you have the opportunity to receive and review upon request. In addition, eHealthScreenings may use or disclose your information pursuant to your direct authorization, as stated below.

Authorization. I understand that participation in the Plan's wellness program is strictly voluntary. I authorize eHealthScreenings, to receive and transmit my Protected Health Information ("PHI"), as defined under HIPAA, for the purpose of processing and exporting my Biometric Screening Results for participation in Plan's wellness program.

I understand and agree that my Biometric Screening Results include general information (such as name, gender, date of birth, Social Security Number, and email address), biometric measurements collected (height, weight, blood pressure, waist circumference), and blood specimen results received from a physician or LabCorp (cholesterol, HDL, LDL, triglycerides, glucose).

I authorize eHealthScreenings to transmit my Biometric Screening Results to the Plan's third-party wellness vendor and if applicable, the Plan and/or my employer. I authorize eHealthScreenings to provide non-PHI participation data (name, confirmation of participation, date form submitted to eHealthScreenings) to the Plan for the purpose of the Plan determining my eligibility for wellness incentives. I understand that this information will not be used to make employment decisions about me, but may be used either by eHealthScreenings or my health and wellness program administrator(s) and related vendors for purposes of administering the employer's health plan and/or health and wellness program.

Effective Time. This authorization will expire four (4) years from the date of signature.

Right to Revoke Authorization. I understand that I may revoke this authorization at any time by submitting notice of my revocation in writing to Premise Health Employer Solutions, LLC, on behalf of eHealthScreenings, Compliance Department, 5500 Maryland Way, Suite 200, Brentwood, TN 37027. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

Signature Authorization. I have read this form in its entirety and voluntarily consent to the data collection and biometrics procedures. I agree to the uses and disclosures of the information as described above. I understand that revoking this authorization does not stop disclosure of health information that has occurred prior to a revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures as provided by HIPAA, 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

I sign this agreement truthfully, knowingly, freely, and voluntarily. I acknowledge that the person executing this Notice & Consent is the person participating in or receiving the biometric screening, or such participant's legal representative, and is authorized to act on such person's behalf to sign this Notice & Consent. The participant is at least 18 years old.

(Participant – Please Print):

First Name: _____ Last Name: _____

Phone Number: _____ Email: _____

Last 4 of SSN: _____ DOB (Month/Day/Year):_____

Participant or Legal Representative Signature:_____ Date: _____

eHealthScreenings
A Premise Health® company

Dental Screening Form

Screening Key: PHE78

SCREENING NAME

Cummins 2020 Dental Cleaning

CRITERIA AND INSTRUCTIONS

Please select the dental visit(s) you are submitting: ☐ **Dental Cleaning #1** ☐ **Dental Cleaning #2**

.

1. All of the information included on this form is required. Any missing information may prevent or delay your information from being processed and impact your program incentive(s).
2. Visits should be no earlier than: **1/1/2020** and no later than: **12/31/2020.**
3. Completed forms can be emailed to **ehs.physicianscreening@ehealthscreenings.com**.

If you do not see your points on the Virgin Pulse portal within 2 weeks after submitting, please contact Premise–EHS Customer Support at 888-708-8807, or email help@ehealthscreenings.com.

Section A | PARTICIPANT INFORMATION (participant to complete)

First Name:	Last Name:
Sex: Last 4 SSN: _____ _____ _____ _____	DOB: (mm/dd/yyyy): _____ / _____ / _____
Phone:	Email:
Participant Signature:	**Date:**

Section B | DENTAL PROVIDER INFORMATION (healthcare provider to complete)

Healthcare Provider & Practice / Facility Name:	
Address:	Phone #:
National Provider ID #:	Visit Date (required): ____ / ____ / _____
Provider Signature:	**Date:**