FAULKNER COUNTY ARKANSAS

FCWP 2024 Biometric Screening Form

This exam must be completed in its entirety by October 15, 2024. Please take this form with you to your Biometric Screening and retain a copy. It is the employee and covered spouse's responsibility to have the form completed, and fax the form to Key Benefit Administrators at: 317-284-7227

THIS SECTION TO BE COMPLETED AND SIGNED BY THE EMPLOYEE			
Employee's Full Name:		***Health Plan Member ID #:***	
Date of Birth:		**Gender**:	☐ Male ☐ Female
Phone Number:		**E-mail Address:**	

BY SUBMITTING THIS FORM TO Key Benefit Administrators (WHETHER OR NOT SIGNED BY YOU), YOU HEREBY CONSENT TO THE USE AND DISCLOSURE OF YOUR HEALTH INFORMATION AS DESCRIBED BELOW.

Use and Disclosure of Your Information:

Key Benefit Administrators treats personally identifiable health information as confidential. The information you provide to us on this form will be used to:

- Determine eligibility for reduced Health Coverage costs.
- Generate a summary report so that your employer can understand the overall health strengths and concerns of the group. Your individual responses cannot be identified in the summary report.
- Inform you about materials, programs and services that might be useful to you.

The information you provide may be disclosed to the following individuals or groups as appropriate (as determined at Key Benefit Administrators sole discretion):

- Authorize Key Benefit Administrators employees;
- Authorized individuals working for your employer or other third parties to the extent reasonably necessary for us to operate employer-sponsored programs in which you participate, provided the receiving party agrees to maintain the confidentiality of your information and information is used only for the purposes noted;
- Assigned contractors, their agents and successors whom we use to support our business in connection with any program sponsored by your employer in which you participate, provided the receiving party agrees to maintain the confidentiality of your information and information is used only for the purposes noted;
- Vendors, contractors and other third parties authorized to provide services and/or programs for your employer's health management plan, provided the receiving party agrees to maintain the confidentiality of your information and information is used only for the purposes noted;
- Those involved with the sale, assignment or transfer of business to which the information you give is related, provided they sign appropriate confidentiality agreements that maintain the confidentiality of your information;
- Those with whom we are required to share your information by applicable law, court orders or government regulations; or
- Health care personnel for treatment purposes including, for example, emergency assistance personnel.

I hereby authorize the medical facility listed below to release biometric assessment data to Key Benefit Administrators.

Facility Name:		Telephone Number:	

Participant Signature:_____ **Date**:_____

THIS SECTION TO BE COMPLETED AND SIGNED BY HEALTHCARE PROVIDER

Is patient fasting? This means has NOT had anything to eat or drink other than water in the last 9-12 hours. ☐ YES ☐ NO

Note: Fasting is not required; however, measurements may be affected.

Height in inches:		**LDL:**		**Triglycerides:**	
Weight in pounds:		**HDL:**		**Glucose:**	
Blood Pressure:	/	**Total Cholesterol:**		**Date:**	
Healthcare Provider Name: (please print):					
Healthcare Provider Signature:					