Trilogy Health Services' On-Site Wellness Program Health Screening Release of Liability, Notice, and Consent

First Name:______________________________ Last Name:______________________________ Date of Birth ______________

Email:____ Phone Number: ______________________

I acknowledge that my participation in this Biometric Health Screening ("BHS") is voluntary. I consent for my BHS to be performed by an employee of Trilogy Management Services, LLC. I understand the results of the oral cotinine test will be shared with my employer for the purpose of qualifying for the insurance wellness rate. Outside of this, my individually identifiable health information will not be shared with my employer beyond the extent of the individual performing the BHS; however, my employer may be advised of the fact of my participation in the BHS.

I understand my individually identifiable information may be shared with and used by Virgin Pulse and my employer-sponsored group health plan to provide health management and/or disease management services including data aggregation for program improvement purposes. Such information will not be used for any other purpose. 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.

I, the undersigned, hereby consent to the collection of blood pressure, pulse, height, weight, BMI readings, waist circumference, body composition data, a mouth swab for the purpose of nicotine detection, and a blood sample for the purpose of measuring my cholesterol and glucose levels.

I hereby release my Employer, my Employer-sponsored group health plan, vendors and individuals used to conduct services required for this BHS, including but not limited to Trilogy Health Services, LLC, Trilogy Management Services, LLC, Virgin Pulse, and such entities' affiliates, subsidiaries, parent organizations, directors, officers, employees, successors and assigns, from any liability arising from or in any way connected with my participation in the BHS and any data derived from the BHS tests.

I understand that:

- The data derived from the test(s) are considered to be preliminary; they are screening assessments only. They do not constitute a medical diagnosis.
- I alone am responsible for initiating a follow-up examination to confirm the results of this screening and obtain professional medical assistance, and not that of any organization(s) associated with this screening.
- The BHS, Trilogy Wellness Program, and Virgin Pulse are administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, as amended ("ADA"); the Genetic Information Nondiscrimination Act of 2008, as amended ("GINA"); and the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPPA"); and others as applicable.
- There are risks associated with the collection of blood through a needle or finger stick including discomfort, bruising, or infection.
- Any medical information that personally identifies me that is provided in connection with the wellness program will not be provided to my supervisors or managers and may never be used to make decisions regarding my employment.
- My results may be disclosed in detail to Virgin Pulse and may also be disclosed in aggregate form to the employer sponsoring this program. Aggregate form means that my data will be combined with those of other participants in a manner, which **does not personally identify me.** I may be identified by name as a participant, but my name will not be associated with any specific screening results. My results will not be shared with my employer or unaffiliated third parties without my express permission, unless required to do so by law. Nicotine results will be used to determine Wellness Discount eligibility. No other results are used to determine my eligibility for insurance coverage or my employment status.
- I have the option of having this BHS performed by the health provider of my choice.

Consent for Health Screening: By participating in this health screening, you understand that certain health issues may be identified, such as high blood glucose and high cholesterol; however, this screening cannot and should not be considered a substitute for a thorough examination by, or testing recommended by, your personal physician. The screening data received by you is for informational use only and should not be considered diagnostic or conclusive.

I HAVE READ THIS RELEASE OF LIABILIY, NOTICE, AND CONSENT in its entirety (or it has been read to me) and I am signing freely and voluntarily. I am the person receiving the health screening, or the legal representative of the person receiving the health screening and am authorized to act on such person's behalf to sign this agreement.

Signature:____ Date: ______________