

BIOMETRIC SCREENING FORM - 2026 Benefits

Submission Deadline: September 30, 2025

Section I: Patient Information (please print clearly) - ALL INFO REQUIRED

Full Name: _____

Gender: _____ Date of Birth: _____

Last 4 of SSN: _____ Phone: _____

E-mail: _____

Employer: _____

Spouse's Information (if applicable):

Full Name: _____

Last 4 of SSN: _____

Is Spouse also a Participant? (Y/N): _____

Form completed for:

Participant ☐

Spouse ☐

NOTE: Biometric screening data and lab work must have been collected between October 1, 2024 and September 30, 2025.

**Biometric Screening Forms are only required if you wish to enroll in the best medical plan available to you. If you have a spouse who is covered under your benefit plan, he/she must also complete a Form.*

Section II: Biometric Screening Data and Lab Work completed between October 1, 2024 and September 30, 2025- ALL INFO REQUIRED

Biometric Screening Data:

Date of Collection

Height (inches)

Weight (pounds)

Blood Pressure (Systolic)

Blood Pressure (Diastolic)

Lab Work:

Date of Collection

Total Cholesterol

HDL Cholesterol

LDL Cholesterol

Triglycerides

Glucose

(and/or)

A1C

Is the patient currently fasting? ____ Yes ____ No

Physician's Name _____ Physician's Phone _____

Physician's Signature _____ Date _____

Section III: Preventive Screenings Completed? - CHECK ONE OPTION BELOW (SCREENINGS NOT REQUIRED):

YES

NO

N/A

Pap Smear (within last 3 years; for women age 21 or older)

Mammogram (within last 1-2 years; for women age 40 or older)

Prostate Cancer Screening (for men age 45 or older with family history)

Colorectal Screening, (men and women over 45, Fecal Occult Blood Test, or Colonoscopy)

Does the patient smoke/chew/use tobacco products?

Please return completed form, signed by the physician, to the Fund Office by September 30, 2025: (Keep a copy for your records)

Mail: 3031 B Walton Road Plymouth Meeting PA, 19462

Fax: (610) 941-9602

Email: fund@1776funds.org

Questions? Call the Fund Office at 610-941-9400