***\*\*Note: In order to receive the contribution incentive, all responses must be either “Yes” or “NA”.***

**SECTION 1. – TO BE COMPLETED BY HEALTH PLAN PARTICIPANT**

**Step 3:** Forward or bring this form to your Primary Care Provider’s office+ for completion. **No appointment is needed if you are**

**up- to-date with the preventive screenings in Section 2 below.** *+Form may also be completed by an OB-GYN or other specialist.*

* **Please request and keep a copy** of your completed Wellness Statement for your records**.**
* **You are responsible to ensure your Wellness Statement is completed by your Provider’s office and is received by November 30, 2023.**

**Due to Human Resources by November 30, 2023 to earn premium contribution for 2024**

**IMPORTANT:** Use this form if you plan to have your primary care provider indicate that you are in compliance with the required preventive screenings to participate in the Fox Valley Tool & Die wellness program.

Office use only:

Date received:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initials\_\_\_\_\_\_\_\_\_\_

**2023 Wellness Statement**

**Step 2: Participant Authorization**

I am participating in the Fox Valley Tool & Die Wellness Program and hereby authorize my Primary Care Provider’s office to complete this document on my behalf in order to receive FVTD’s wellness benefit for 2024. **I also acknowledge that it is my responsibility to ensure my Wellness Statement is completed by my Provider’s office and is received by HR by 11/30/2023.**

**\*\*If there is an extenuating circumstance that requires your physical, biometric testing, or teeth cleaning in December of 2023, please talk to HR to give them advance notice your form will be late.** *Please sign and date below, and continue to Step 3.*

(Signature)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Date)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Step 1: Please complete all information below:**

**Employee Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*(Employee that carries plan coverage) (please print)*

**Participant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_**

*(Either Employee or Spouse) (please print)*

I am a *(check one box)*: Employee Spouse Participant

**SECTION 2. – TO BE COMPLETED BY PRIMARY CARE PROVIDER’S OFFICE**

**Step 1: Please circle Yes, No or NA to indicate participant achievement\*\*:**

**Physical Exam(s):**

*Annually for all men and women*  **Yes No**

**Biometric Screening:**

*Including BMI, Blood Pressure, Blood Glucose, Cholesterol & Trigliderides*  **Yes No**

**Dental Exam/Cleaning:**

*One annual dental cleaning and exam* **Yes No**

**Step 2: Please complete Provider Verification below.**

Signature of Provider’s Designee:

Name (please print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­ (Signature)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Date)\_\_\_\_\_\_\_\_\_\_\_\_\_\_