WISCONSIN
UNIVERSITY OF WISCONSIN-MADISON

WELL WISCONSIN
Healthier starts with you

获得$150 的保健奖励

各位员工：

如果您符合条件，您将能获得**$150 的保健奖励**。您所在的部门无法在新冠肺炎疫情期间提供现场体检。您必须在 **2020 年 10 月 9 日**之前完成以下 2 步：

第 1 步： 填写健康问卷调查表（在选项 1、2 和 3 中选择一项）

- **选项 1：纸质**
  拨打 *StayWell* 电话 1-800-821-6591，索要纸质的英语或西班牙语版的健康调查表。

- **选项 2：电话**
  拨打 *StayWell* 电话 1-800-821-6591，在电话中完成健康调查表。我们在电话中可以提供各个语种的口译服务。

- **选项 3：网络**
  在 www.wellwisconsin.staywell.com 完成英语或西班牙语版的健康调查表。**注意：**如果您选择了选项 3：网络，您必须**还要**通过您的 *StayWell* 保健账户，在 2020 年 10 月 9 日之前完成一项**安康活动（*Well-being Activity*）**，才能获得$150 的 *Visa* 礼品卡（*Gift Card*）。

第 2 步：检查身体（*Health Check*）（在选项 1 和 2 中选择一项）

- **选项 1： 纸质**
  使用您最近一次见医生时测量的数据填写纸质的**医护人员（*Health Care Provider*）表格。**
  您必须要填写您的：
  - *Height*（身高）
  - *Weight*（体重）
  - *Blood Pressure*（血压）

- **选项 2： 电话**
  打电话参加一次**指导课程（*coaching session*）**。请拨打 *StayWell* 电话 1-800-821-6591 预约参加。您可以在电话中获得口译服务。

如果您在 2020 年 10 月 9 日之前完成了**第 1 步和第 2 步**，您就会自动收到邮寄给您的$150 的 *Visa* 礼品卡（*Gift Card*）。**如果您在 2020 年 10 月 23 日时还没有收到礼品卡，请给 *StayWell* 打电话。**

有疑问？拨打 *StayWell* 求助热线 1-800-821-6591。

**StayWell*为参加威斯康星州集体医疗保险的参保人发放的所有保健奖励对参保人来说都是要交税的收入。因为这个税务原因，我们将向您的工作单位报告您得到的这笔钱。您的医疗信息，包括您在调查表上的回答，都是受联邦法律保护的，我们绝不会向 *ETF*、集体医疗保险项目或是您的单位透露这些信息。
**本活动凭自愿参加。它不能取代医生对您的护理。体检和健康问卷调查都不能为您诊断疾病，也不能推荐治疗方案。

如何填写并提交您的医护人员（*Health Care Provider*）表格

请使用您最近一次见医生时所测量的数据来填写医护人员表格。您必须在**2020年10月9日**之前提交填好的医护人员表格。

第1步：填写您的：

- *First Name*（名）
- *Last Name*（姓）
- *Date of Birth (Month, Day, Year)*［生日（月、日、年）］

第2步： 阅读有关知情同意（*consent*）的信息，然后，

- 签名
- 写上当日日期

第3步：以下是必填项，请使用您最近一次见医生时测量的数据 。

- *Blood Pressure*（血压）
  - *Systolic*（收缩压/高压）
  - *Diastolic*（舒张压/低压）
  - 测量日期
- *Height*（身高）
  - 英尺
  - 英寸
- *Weight (pounds)*［体重（磅）］
  - 测量日期

第4步： 在**2020年10月9日**之前提交填好的医护人员表格。

- 发送传真至240-477-1521，或
- 邮寄至：

  US Wellness
  20400 Observation Drive #100
  Germantown, MD 20876

有疑问？欢迎拨打 *StayWell* 求助热线 1-800-821-6591。

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HEALTH CARE PROVIDER FORM – WELL WISCONSIN PROGRAM

Complete Steps 1-4 on this form to verify that you are current on your preventive healthcare. Submit this form by October 9, 2020. Print clearly.

STEP 1: Please note this information must match your health insurance enrollment data

First Name

Last Name

Date of Birth (Month Day Year)

Phone Number

E-mail address

STEP 2: Complete

I understand that StayWell and US Wellness, Inc. may use and disclose my personally identifiable information and screenings results collected on this form (my "Personal Information"), in order to provide wellness program services to me, on behalf of the sponsoring entity. Except for my actual screening results, StayWell may provide my Personal Information to my sponsoring entity or its designated representative to (I) notify them of whether I am eligible for the incentive, and/or (ii) provide them with program participation information. StayWell and US Wellness, Inc. may use my Personal Information for anonymous group statistical research and analysis and may combine my Personal Information with information collected from other participants to create anonymous aggregate data reports. StayWell may provide my Personal Information to (I) my health plan or its vendors for purposes of treatment, payment, and health care operations, including benefits administration, appeals, and incentive management, and (ii) the plan sponsor of my health plan for plan administration functions in accordance with the 45 C.F.R. 164.504. The Well Wisconsin Program ("Program") is a voluntary wellness program administered per the Genetic Information Nondiscrimination Act ("GINA") and other applicable law. If you participate in the Program, you will be asked to complete a voluntary health risk assessment, which requests certain information, including whether you have ever had certain medical conditions, diseases or disorders ("Protected Information"). The Program uses Protected Information to help you understand potential health risks and to offer disease management programs, coaching and other services. The Program safeguards the privacy and security of any Protected Information you provide consistent with applicable law. Protected Information may be disclosed to you and any licensed health care professionals or board certified genetic counselors to provide you with Program services and will not be sold, exchanged, transferred or otherwise disclosed, except as permitted by law to carry out Program-related activities. You will not be asked to waive the confidentiality of this information as a condition of participating in the Program or receiving any incentive. No Protected Information will be used in making any employment decision and such information will be disclosed to your employer only in aggregate terms that do not disclose your specific identity.

X _____

Participant Signature Authorizing Disclosure (REQUIRED) **Date**

STEP 3: Complete

PREGNANT ◯ **Yes** ◯ **No**

REQUIRED VALUES

Blood Pressure

Systolic /

Diastolic

Date of Test

(Month) (Day) (Year)

Height

(Feet) (Inches)

Weight (lbs)

Date of Measurement

(Month) (Day) (Year)

ADDITIONAL VALUES* (if recommended by your doctor)

Cholesterol

Total Cholesterol

HDL Cholesterol

LDL Cholesterol

Triglycerides

Were you fasting for more than 8 hours prior to this test? ◯ Yes ◯ No

Date of Test:

(Month) (Day) (Year)

Glucose (Blood Sugar)

Were you fasting for more than 8 hours prior to this test?

◯ Yes ◯ No

Date of Test

(Month) (Day) (Year)

*Please note, you may be responsible for out of pocket costs associated with these lab tests.

Health Care Provider Name | Health Care Clinic | Phone Number

STEP 4: Submit Form by 10/09/2020

Participant may fax this form to 240-477-1521, mail it to US Wellness at 20400 Observation Drive #100, Germantown, MD 20876 or securely upload it electronically at https://wellwi.uswellness.com/offsite. If you entered your email address, you will receive verification that your form has been received within two business days.

US Wellness, Inc 20400 Observation Drive #100, Germantown, MD 20876 p: 866-926-6099x900 f: 240-477-1521