Kom Tau Txais $150 Muab Pub Kev Ntsuam Noj Qab Haus Huv

Cov Neeg ua Haujlwm,

Yog koj muaj feem, koj yuav tau txais **$150 muab pub rau Kev Ntsuam Noj Qab Haus Huv**. Vim tus kab mob COVID 19 koj ceg ua haujlwm yuav tsis muaj neeg tuaj ntsuam ntawm chaw ua haujlwm. Koj yuav tsum ua ob qho hauv qab no kom tiav ua ntej lub **Kaum Hli xiab 9, 2020**:

Ruam 1: Daim ntawv nug ntsuam koj kev noj qab haus huv (Xaiv Qhov 1, 2, los 3.)

- **Qhov 1**: **Daim ntawv lus nug**
  Hu StayWell rau 1-800-821-6591 kom xa daim ntawv muaj cov lus nug ntsuam kev noj qab haus huv rau lus Askis los *Spanish*.

- **Qhov 2: Xovtooj**
  Hu StayWell rau 1-800-821-6591 teb daim ntawv muaj cov lus nug ntsuam kev noj qab haus huv. Muaj neeg txhais lus rau txhua yam lus.

- **Qhov 3: Online**
  Teb cov lus nug ntsuam kev noj qab haus huv muaj ntawv Askis los *Spanish* nyob online hauv www.wellwisconsin.staywell.com. **Tseem Ceeb:** Rau Qhov 3: Online, koj kuj tseem yuav tsum tau ua kom tiav ib qho ***Well-being Activity*** ua ntej lub Kaum Hli xiab 9, 2020 hauv lub StayWell portal thiaj yuav tau txais koj daim $150 *Visa Gift Card.*

Ruam 2: Koj Qhov Kuaj Ntsuam (Xaiv Qhov 1 los 2.)

- **Qhov 1: Daim ntawv (koj teev)**
  Teev kom tiav daim ntawv ***Healthcare Provider form*** siv cov ntaub ntawv (lej) muaj nyob hauv daim ntawv zaum tas no koj mus ntsib koj tus kws kuaj mob.

  Nws yuav tsum muaj:
  - *Height* (Siab npaum cas)
  - *Weight* (Nyhav npaum cas)
  - *Blood Pressure* (Leeg ntshav nruj npaum cas)

- **Qhov 2: Xovtooj**
  Hu xovtooj muaj **ib tu qhia ua (*coaching session*)** ntsuas. Hu StayWell rau 1-800-821-6591 kom teem ib lub caij. Muaj neeg txhais lus rau txhua yam lus hauv xovtooj.

Yog koj ua **Ruam 1 thiab 2** tiav ua ntej lub Kaum Hli xiab 9, 2020, koj yuav cia li tau txais daim $150 *Visa Gift Card* xa tuaj rau koj. **Yog koj tsis tau txais koj daim *Gift Card* rau lub Kaum Hli xiab 23, 2020, hu StayWell.**

Puas muaj lus nug? Hu StayWell Helpline rau 1-800-821-6591.

*Tag nrho cov nyiaj them pub rau cov neeg koom ntawm Xeev Wisconsin qhov Paj Kais Phais Kuaj Mob uas StayWell yog qhov khiav haujlwm yog nyiaj yuav tau them se rau cov neeg thiab yuav qhia rau chaw ua num rau kev laij se. Ntaub ntawv kuaj, nrog rau cov lus teb txog kev noj qab haus huv, txwv raws nomtswv teb chaws tus cai lijchoj thiab yuav tsis qhia rau ETF, Pawg Tuav Cov Paj Kais Phais Kuaj Mob los koj qhov chaw ua haujlwm.
*Qhov kev koom no nyob ntawm yeem. Nws tsis yog ib qho hloov koj tus kws kho mob kev kuaj. Qhov ntsuam thiab teb daim ntawv txog kev noj qab haus huv yuav tsis tau tias mob li cas los qhia kom yuav tau ua li cas ntxiv.

WISCONSIN
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WELL WISCONSIN
Healthier starts with you

Yuav Teev Daim Ntawv Chaw Kuaj Mob Siv Ntsuam Li Cas

Teev kom tiav daim ntawv chaw kuaj mob siv ntsuam siv cov lej nyob hauv daim ntawv koj mus kuaj mob zaum tas no. Daim ntawv chaw kuaj mob siv ntsuam yuav tsum xa tsis pub dhau lub **Kaum Hli xiab 9, 2020**.

- Siv cov ntaub ntawv zaum tas no koj mus ntsib kws kuaj mob.
- Yog koj teev daim ntawv no tiav, koj **tsis** tau hu StayWell Kuaj Ntsuam.

Ruam 1: Teev koj:
- *First Name* (Lub Npe)
- *Last Name* (Lub Xeem)
- *Date of Birth (Month, Day, Year)* (Hnub Yug (Hli/Hnub/Xyoo)

Ruam 2: Twm cov ntawv txog kev tso cai. Ces,
- Kos koj lub npe rau
- Sau hnub rau

Ruam 3: Teev cov ntawv/lej yuav kom rau, zaum koj mus ntsib kws kuaj mob tas no muaj nyob hauv rau.
- *Blood Pressure* (Hlab ntshav nruj)
    - *Systolic* (Qhov siab)
    - *Diastolic* (Qhov qis)
    - *Date of Test* (hnub ntsuas)
- *Height* (Siab npaum li cas)
    - *Feet* (Ruam)
    - *Inches* (Ntiv)
- *Weight* (*pounds*) – Nyhav npaum cas(phaus)
    - Hnub luj

Ruam 4: Xa daim ntawv chaw kuaj mob siv ntsuam tsis pub dhau lub **Kaum Hli xiab 9, 2020**
- *Fax* rau 240-477-1521, los
- Xa rau:

    US Wellness
    20400 Observation Drive #100
    Germantown, MD 20876

Puas muaj lus nug? Hu StayWell Helpline rau 1-800-821-6591.

*Tag nrho cov nyiaj them pub rau cov neeg koom ntawm Xeev Wisconsin qhov Paj Kais Phais Kuaj Mob uas StayWell yog qhov khiav haujlwm yog nyiaj yuav tau them se rau cov neeg thiab yuav qhia rau chaw ua num rau kev laij se. Ntaub ntawv kuaj, nrog rau cov lus teb txog kev noj qab haus huv, txwv raws nomtswv teb chaws tus cai lijchoj thiab yuav tsis qhia rau ETF, Pawg Tuav Cov Paj Kais Phais Kuaj Mob los koj qhov chaw ua haujlwm.
*Qhov kev koom no nyob ntawm yeem. Nws tsis yog ib qho hloov koj tus kws kho mob kev kuaj. Qhov ntsuam thiab teb daim ntawv txog kev noj qab haus huv yuav tsis tau tias mob li cas los qhia kom yuav tau ua li cas ntxiv.

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