Earn a $150 Wellness Reward

Employees,

If you are eligible, you can receive a **$150 Wellness Reward**. Your department cannot offer onsite health screenings during the COVID 19 Pandemic. You must complete these 2 steps **by October 9, 2020:**

Step 1: Your Health Assessment (Choose Option 1, 2, or 3.)

- **Option 1**: **Paper**
  Call StayWell at 1-800-821-6591 to ask for a paper Health Assessment in English or Spanish.

- **Option 2: Phone**
  Call StayWell at 1-800-821-6591 to complete your Health Assessment by phone. Interpretation services are available for all languages by phone.

- **Option 3: Online**
  Complete your Health Assessment online at www.wellwisconsin.staywell.com in English or Spanish.
  Important: For Option 3: Online, you must **also** complete a **Well-being Activity** by October 9, 2020 through your StayWell wellness portal to get your $150 Visa Gift Card.

Step 2: Your Health Check (Choose Option 1 or 2.)

- **Option 1: Paper**
  Complete the paper **Healthcare Provider form** with information from your last doctor visit.

  You must include your:
  - Height
  - Weight
  - Blood Pressure

- **Option 2: Phone**
  Complete one **coaching session** by phone. Call StayWell at 1-800-821-6591 for an appointment. Interpretation services are available by phone.

If you complete **Steps 1 and 2** by October 9, 2020, you will automatically get your $150 Visa Gift Card in the mail. **If you don't receive your Gift Card by October 23, 2020, call StayWell.**

Questions? Call StayWell Helpline at 1-800-821-6591.

*All wellness incentives paid to participants of the State of Wisconsin Group Health Insurance Programs by StayWell are considered taxable income to the group health plan subscriber and are reported to your employer for tax purposes. Health information, including responses to the health assessment, are protected by federal law and will never be shared with ETF, the Group Health Insurance Program or your employer.

*This event is voluntary. It does not take the place of your doctor's care. The health-screening and health assessment do not diagnose problems or recommend treatments.

How to Complete the Health Care Provider Form

Complete the Health Care Provider Form using results from your most recent health care provider visit. The Health Care Provider Form must be submitted by **October 9, 2020**.

Step 1: Fill in your:

- First Name
- Last Name
- Date of Birth (Month, Day, Year)

Step 2: Read the information about consent. Then,

- Sign your name
- Write the date

Step 3: Fill in the required screening information from your most recent doctor visit.

- Blood Pressure
  - Systolic
  - Diastolic
  - Date of Test
- Height
  - Feet
  - Inches
- Weight (pounds)
  - Date of Measurements

Step 4: Submit the Health Care Provider Form by **October 9, 2020**

- Fax to 240-477-1521, or
- Mail to:

  US Wellness
  20400 Observation Drive #100
  Germantown, MD 20876

Questions? Call StayWell Helpline at 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