



Earn a \$150 Wellness Reward

Employees,

If you are eligible, you can receive a **\$150 Wellness Reward**. You must complete these 2 steps **by October 8, 2021**:

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

- **Option 1: Paper**
Call StayWell/WebMD at 1-800-821-6591 to ask for a paper Health Assessment in English or Spanish.
- **Option 2: Phone**
Call StayWell/WebMD 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 webmdhealth.com/wellwisconsin in English or Spanish.
Important: For Option 3: Online, you must **also** complete a **Well-being Activity** by October 8, 2021 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/WebMD at 1-800-821-6591 for an appointment. Interpretation services are available by phone.

If you complete **Steps 1 and 2** by October 8, 2021, you will automatically get your \$150 Visa Gift Card in the mail.

Questions? Contact StayWell/WebMD at 1-800-821-6591 or CustomerSupport@webmd.net

*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.



Complete Your Health Care Provider Form

Complete and submit this form by **October 8, 2021** for your \$150 Wellness Reward.

- Use information from your most recent doctor visit.
- If you complete this form, you do **not** need to call StayWell/WebMD for a Health Check.

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.

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

Step 4: Submit the Health Care Provider Form by **October 8, 2021**

- Fax to 402-939-0604, or
- Mail to:
TotalWellness,
Attn: Data Team,
9320 H Court,
Omaha, NE 68127
- Securely upload electronically at totalwellnesshealth.com/gravity-landing/wellwi/

Questions? Call StayWell/WebMD 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 8, 2021. Print clearly.

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

<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>
First Name	Last Name
<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
Date of Birth (Month Day Year)	Phone Number
<input style="width: 100%; height: 20px;" type="text"/>	
E-mail address	

STEP 2: Complete

Disclosure of Information. I understand that the information submitted on this form (my "Personal Information") will be transferred to WebMD by TotalWellness. My Personal Information is used by WebMD to provide wellness program services to me, which includes using the Personal Information to inform me of relevant health related and health education programs offered by WebMD or by another service contractor. In the event that WebMD's services are transitioned to another service provider, WebMD may deliver my Personal Information to the successor provider to maintain a continuity of services for me. In order to distribute any incentives, WebMD may provide my name/unique ID to my employer or its designated representative to notify them of the fact that I am eligible for the incentive. In addition to any Personal Information disclosed as set forth above, aggregate, de-identified survey results may be made available to my employer for program administration purposes. WebMD may also use my Personal Information as part of group statistical research and analysis, in a manner that does not identify me. I also understand that my Personal Information may be incorporated into my Health Assessment results by WebMD. Except for these types of usage and the uses specified in my WebMD Online terms of use and Privacy Policy, available under the "Policies" link at the bottom of the following URL (webmdhealth.com/wellwisconsin), my Personal Information will not be disclosed by WebMD. WebMD understands that Personal Information may be considered protected health information that is subject to the privacy and security rules of the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"). WebMD will comply with the HIPAA to the extent applicable.

GINA Notice and Authorization. This screening is part of your employer's wellness program ("Employer Program"), which is a voluntary wellness program administered according to federal rules, including the Genetic Information Nondiscrimination Act ("GINA"). The results of this screening may be considered information protected under GINA ("GINA Protected Information"). GINA requires that you receive this GINA Notice and Authorization prior to undergoing the screening. Your Employer Program uses GINA Protected Information to help you understand your potential health risks and to offer you other wellness program services. The Employer Program safeguards GINA protected information and will not disclose any GINA Protected Information, except as permitted by GINA and other applicable law. Your GINA Protected Information will be disclosed to you and to vendors of the Employer Program, for purposes of providing you with Employer Program services. Your GINA Protected Information will not be sold, exchanged or transferred, except to the extent permitted by law to carry out activities related to the Employer Program. You will not be asked to waive the confidentiality of this information as a condition of participating in the Employer Program or as a condition of receiving any incentive. Your GINA Protected Information will only be disclosed to your employer in aggregate terms that do not disclose your specific identity. You may not be discriminated against in employment because of the GINA Protected Information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

Certification: By signing this form, I certify that the information supplied on this form is accurate and has been provided by me or by my physician.

X _____ Date _____
 Participant Signature Authorizing Disclosure (REQUIRED)

STEP 3: Complete

PREGNANT Yes No

REQUIRED VALUES	ADDITIONAL VALUES* (if recommended by your doctor)																			
<p>Date of Test</p> <table style="width: 100%; text-align: center;"> <tr> <td style="width: 20%;"><input style="width: 20px; height: 20px;" type="text"/></td> <td style="width: 20%;"><input style="width: 20px; height: 20px;" type="text"/></td> <td style="width: 60%;"><input style="width: 60px; height: 20px;" type="text"/></td> </tr> <tr> <td>(Month)</td> <td>(Day)</td> <td>(Year)</td> </tr> </table> <p>Blood Pressure</p> <table style="width: 100%;"> <tr> <td style="width: 15%;">Systolic</td> <td style="width: 15%;"><input style="width: 20px; height: 20px;" type="text"/></td> <td style="width: 5%; text-align: center;">/</td> <td style="width: 15%;"><input style="width: 20px; height: 20px;" type="text"/></td> </tr> <tr> <td>Diastolic</td> <td><input style="width: 20px; height: 20px;" type="text"/></td> <td></td> <td><input style="width: 20px; height: 20px;" type="text"/></td> </tr> </table> <p>Height</p> <table style="width: 100%; text-align: center;"> <tr> <td style="width: 20%;"><input style="width: 20px; height: 20px;" type="text"/></td> <td style="width: 20%;"><input style="width: 20px; height: 20px;" type="text"/></td> </tr> <tr> <td>(Feet)</td> <td>(Inches)</td> </tr> </table> <p>Weight (lbs)</p> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 60px; height: 20px;" type="text"/>	(Month)	(Day)	(Year)	Systolic	<input style="width: 20px; height: 20px;" type="text"/>	/	<input style="width: 20px; height: 20px;" type="text"/>	Diastolic	<input style="width: 20px; height: 20px;" type="text"/>		<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	(Feet)	(Inches)	<p>Cholesterol</p> <p>Total Cholesterol <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/></p> <p>HDL Cholesterol <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/></p> <p>LDL Cholesterol <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/></p> <p>Triglycerides <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/></p> <p>Were you fasting for more than 8 hours prior to this test? <input type="radio"/> Yes <input type="radio"/> No</p>	<p>Glucose (Blood Sugar)</p> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <p>Were you fasting for more than 8 hours prior to this test? <input type="radio"/> Yes <input type="radio"/> No</p> <p style="font-size: small;">*Please note, you may be responsible for out of pocket costs associated with these lab tests.</p>
<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 60px; height: 20px;" type="text"/>																		
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(Feet)	(Inches)																			

Health Care Provider Name	Health Care Clinic	Phone Number
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STEP 4: Submit Form by 10/08/2021 Participant may fax this form to 402-939-0604, mail it to TotalWellness, Attn: Data Team, 9320 H Court, Omaha, NE 68127 or securely upload it electronically at totalwellnesshealth.com/gravity-landing/wellwi/. If you entered your email address, you will receive verification that your form has been received within two business days.