Your $150 Wellness Reward

Employees,

It's easy to get your $150 Wellness Reward! By **October 14, 2022**, complete your:

1. **Health Assessment**
   - Call 1-800-821-6591 to do your Health Assessment **by phone**. You can ask for a language interpreter.

     or

   - Call 1-800-821-6591 to ask for a **paper** Health Assessment in English or Spanish. (For a different language, do your Assessment with an interpreter by phone.)

2. **Health Check**
   - Call 1-800-821-6591 to schedule a **30-minute coaching session**. Coaching sessions are by phone. You can ask for an interpreter.

     or

   - Complete the **Healthcare Provider Form**.
     - Take the form to a doctor's appointment, or use information from your last appointment.
     - Mail your completed form **before October 14, 2022**.
     - You only need to write your: **blood pressure, height,** and **weight**.

If you do a **Heath Assessment** and **Health Check** by October 14, you will get a $150 Visa Gift Card in the mail.

If you don't get your gift card by November 14 (or if you have questions), call 1-800-821-6591.

*The $150 incentive is taxable income and is reported to your employer for tax purposes.
*You do not have to participate in this incentive. We will not share your health information or assessment with ETF, Group Health Insurance Program, or your employer.
*This program does not replace your doctor's care. The health-screening and assessment do not diagnose problems or recommend treatments. Always talk to your doctor about your health.

Complete Your Health Care Provider Form

Complete this form by **October 14, 2022**.

- Take the form to a doctor's appointment, or use information from your last appointment.
- If you do this form, you do **not** need to do a coaching session by phone.

Step 1 - Write your:

- first and last name (same as it is on your employer's records)
- date of birth (month, day, year)

Step 2 - Write your:

- blood pressure (systolic and diastolic)
- height (feet and inches)
- weight (pounds)

(The other information in Step 2 is **optional**. You do **not** need to write it.)

Step 3 - Read the information about consent. Then:

- sign your name
- write the date

Step 4 - Submit this form by **October 14, 2022**, by:

- fax: 402-218-4378,
- electronic upload: totalwellnesshealth.com/gravity-landing/wellwi/, or
- mail:

  TotalWellness
  Attn: Data Team
  9320 H Court
  Omaha, NE 68127

Questions? Call 1-800-821-6591

*The $150 incentive is taxable income and is reported to your employer for tax purposes.
*You do not have to participate in this incentive. We will not share your health information or assessment with ETF, Group Health Insurance Program, or your employer.
*This program does not replace your doctor's care. The health-screening and assessment do not diagnose problems or recommend treatments. Always talk to your doctor about your health.

Health Care Provider Form – Well Wisconsin Program

Instructions:

Complete Steps 1-4 on this form to verify that you are current on your preventive healthcare.
Submit this form by **October 14, 2022**. Print clearly.

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

First Name:

Last Name:

Date of Birth: (mm/dd/yyyy)

/ /

Email: (Required to provide confirmation of form receipt.)

Have you fasted for at least 9 hours? (*No food. Only water permitted.*) ☐Yes ☐No

Are you pregnant? ☐Yes ☐No

Step 2: Complete

Date of Screening: (mm/dd/yyyy) / /

REQUIRED Blood Pressure: / (Systolic / Diastolic)

REQUIRED Height: (Ft. / Inches)

REQUIRED Weight: (Lbs.)

Waist: (Inches)

Glucose:

Total Cholesterol:

HDL:

LDL:

Triglycerides:

Health Care Provider Name: _____ **Phone Number:** _____

Health Care Clinic: _____

Step 3: 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 by my physician.

X _____ _____

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

Step 4: Submit Form by 10/14/2022 Participant may fax this form to 402-218-4378, 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.