中文 / ***CHINESE***

您的$150 保健奖励

各位员工：

您很容易就可以得到$150 的保健奖励！请在 **2023 年 10 月 13 日**之前完成：

1. **健康问卷调查（*Health Assessment*）**
   - 拨打 1-800-821-6591，**在电话中**完成健康问卷调查。如果需要，您可以要求口译服务。

     或者

   - 拨打 1-800-821-6591，索要**纸质**的英语或西班牙版健康调查问卷。（如需其它语言服务，请按照上方所述的在电话中通过口译员协助完成问卷调查）。

2. **健康状况评估（*Health Check*）**
   - 拨打 1-800-821-6591，预约一次 **30 分钟的指导课程（*coaching session*）**。指导课程将通过电话完成。您可以要求口译服务。

     或者

   - 填写**医护人员表格（*Healthcare Provider Form*）**。
     - 在见医生时请带上这个表格请医生填写，或是用上次见医生时测量的数据。
     - 在 **2023 年 10 月 13 日前**邮寄填好的表格。
     - 您只需填写您的：**血压（*blood pressure*）**、**身高（*height*）**和**体重（*weight*）**。

如果您在 10 月 13 日之前完成**健康问卷调查**和**健康状况评估**，您将通过邮寄形式获得$150 的 *Visa* 礼品卡（*Gift Card*）。

如果您在 12 月 15 日前没有收到礼品卡（或是如果您有疑问），请拨打电话 1-800-821-6591。

*$150 的保健奖励属于要交税的收入，所以由于税务原因，我们将向您的工作单位报告您的这笔收入。
*您不是必须要参与该奖励计划。我们绝不会向 *ETF*、集体医疗保险项目或您的工作单位透露您的医疗信息或问卷调查结果。
*本计划不能取代医生对您的护理。健康状况评估和问卷调查都不能为您诊断疾病，也不能推荐治疗方案。请与您的医生讨论您的健康问题。

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

请在**2023年10月13日之前**填好并提交本表格。

- 在见医生时请带上这个表格请医生填写，或是用上次见医生时测量的数据。
- 如果您填写了本表格，您就**不需要**通过电话完成指导课程（*coaching session*）。

第1步 - 请填写您的：

- *first name*（名）和*last name*（姓）（请确保您的姓名和您在工作单位的记录中的姓名一致）
- *date of birth (month, day, year)* [生日（月、日、年）]

第2步 - 请填写您的：

- *blood pressure (systolic and diastolic)* [血压（高压和低压）]
- *height (feet and inches)* [身高（英尺和英寸）]
- *weight (pounds)* [体重（磅）]

（第2步中的其它内容都**不是必填项**。也就是说您可以**不填**。）

第3步 - 阅读有关知情同意（*consent*）的信息。然后：

- 签名
- 写上当天的日期

第4步 - 在2023年10月13日之前通过以下任何一种方式提交您填好的表格：

- 传真：402-218-4378,
- 上传电子版至：totalwellnesshealth.com/gravity-landing/wellwi/ 或
- 邮寄至：

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

有疑问？ 拨打电话1-800-821-6591

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*您不是必须要参与该奖励计划。我们绝不会向 *ETF*、集体医疗保险项目或您的工作单位透露您的医疗信息或问卷调查结果。
*本计划不能取代医生对您的护理。健康状况评估和问卷调查都不能为您诊断疾病，也不能推荐治疗方案。请与您的医生讨论您的健康问题。

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 13, 2023**. 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.)

Did you fast for at least 9 hours before your lab work or screening? (*No food. Only water permitted.*) ◯Yes ◯No

Are you pregnant? ◯Yes ◯No ◯N/A

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 10/13/2023 Participants 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.