नेपाली / *NEPALI*

तपाईंको $150 को स्वास्थ्य सम्बन्धी ईनाम (*Wellness Reward*)

कर्मचारीहरू,

तपाईंको $150 को स्वास्थ्य सम्बन्धी ईनाम (*Wellness Reward*)! **अक्टोबर १३, २०२३** भित्रमा यी कुराहरू पूरा गर्नुहोला:

1. **स्वास्थ्य मूल्याङ्कन**
   - **फोन मार्फत** तपाईंको स्वास्थ्य मूल्याङ्कन गर्नका लागि 1-800-821-6591 मा फोन गर्नुहोला। तपाईंले दोभाषेको अनुरोध गर्न सक्नुहुनेछ।

     वा

   - अङ्ग्रेजी वा स्पैनिश भाषाको **कागजी** स्वास्थ्य मूल्याङ्कन फारामको लागि 1-800-821-6591 मा फोन गर्नुहोला। (बेग्लै भाषाको लागि, तपाईंको मूल्याङ्कन फोन मार्फत पूरा गर्नुहोला।)

2. **स्वास्थ्य जाँच**
   - **३० मिनेटको** फोन मार्फतको **स्वास्थ्य कोचिङ्ग भेटघाटको** लागि 1-800-821-6591 मा फोन गर्नुहोला। तपाईंले दोभाषेको अनुरोध गर्न सक्नुहुनेछ।

     वा

   - **स्वास्थ्य सेवा प्रदायक (*Healthcare Provider Form*)** फाराम पूरा गर्नुहोला।
     - यो फाराम तपाईंको डाक्टरसँगको भेटघाटमा लग्नुहोला वा तपाईंको अघिल्लो भेटघाटको जानकारीको प्रयोग गर्नुहोला।
     - फाराम भरेर **अक्टोबर १३, २०२३** भित्रमा हुलाक मार्फत पठाउनुहोला।
     - तपाईंले यी कुराहरू मात्र लेख्नुपर्नेछ: **रक्तचाप, उचाई र वजन *(blood pressure, height,* र *weight)***।

यदि तपाईंले अक्टोबर १३ भित्र **स्वास्थ्य मूल्याङ्कन** र **स्वास्थ्य जाँच** गर्नुभयो भने, तपाईंले हुलाक मार्फत $150 को *Visa Gift Card* पाउनुहुनेछ।

तपाईंले डिसेम्बर १५ भित्र तपाईंको *gift card* पाउनुभएन भने (वा यदि तपाईंसँग प्रश्नहरू छन् भने), 1-800-821-6591 मा फोन गर्नुहोला।

*$150 को रकम कर लाग्ने आमदानी हो र करको उद्देश्यको लागि तपाईंको रोजगारदातालाई रिपोर्ट गरिन्छ।
*तपाईंले यो कार्यक्रममा भाग लिन आवश्यक छैन। हामीले तपाईंको स्वास्थ्य जानकारी वा मूल्याङ्कन *ETF*, *Group Health Insurance Program*, वा तपाईंको रोजगारदातालाई प्रदान गर्ने छैनौं।
*यो कार्यक्रमले तपाईंको डाक्टरको हेरचाह साट्दैन। स्वास्थ्य जाँच र मूल्याङ्कनहरूले समस्याहरू पत्ता लगाउँदैनन् वा उपचाहरूको सल्लाह दिँदैनन्। आफ्नो स्वास्थ्यको बारेमा सधैँ आफ्नो डाक्टरसँग कुरा गर्नुहोला।

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तपाईंको स्वास्थ्य सेवा प्रदायक (*Health Care Provider*) फाराम पूरा गर्नुहोस्

यो फाराम भरेर **अक्टोबर १३, २०२३** भित्र भर्नुहोला।

- यो फाराम तपाईंको डाक्टरसँगको भेटघाटमा लग्नुहोला वा तपाईंको अघिल्लो भेटघाटको जानकारीको प्रयोग गर्नुहोला।
- यदि तपाईंले यो फाराम पूरा गर्नुभयो भने, तपाईंले फोन मार्फत स्वास्थ्य कोचसँग कुरा गर्नुपर्ने **छैन**।

पाइला १ - तपाईंको यी जानकारी भर्नुहोस्:

- नाम र थर (तपाईंको काममा जे छ त्यही)
- जन्म मिति (महिना, दिन, वर्ष)

पाइला २ - तपाईंको यी जानकारी भर्नुहोस्:

- रक्तचाप (*blood pressure* (*systolic* र *diastolic*))
- उचाई (*height* (*feet* र *inches* मा))
- वजन (*weight*) (पाउन्डमा)

(पाइला २ का अरू जानकारी **आवश्यक छैनन्**। तपाईंले ती जानकारी **भर्नुपर्दैन**।)

पाइला ३ - स्वीकृति सम्बन्धीको जानकारी पढ्नुहोला। त्यसपछि:

- तपाईंको हस्ताक्षर दिनुहोला
- मिति लेख्नुहोला

पाइला ४ - अक्टोबर १३, २०२३ भित्रमा यो फाराम भरेर यसरी बुझाउनुहोला:

- फ्याक्स गरेर: 402-218-4378,
- अन्लाईन अपलोड गरेर: totalwellnesshealth.com/gravity-landing/wellwi/, वा
- हुलाक मार्फत:

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

प्रश्नहरू छन् ? 1-800-821-6591 मा फोन गर्नुहोला

*$150 को रकम कर लाग्ने आमदानी हो र करको उद्देश्यको लागि तपाईंको रोजगारदातालाई रिपोर्ट गरिन्छ।
* तपाईंले यो कार्यक्रममा भाग लिन आवश्यक छैन। हामीले तपाईंको स्वास्थ्य जानकारी वा मूल्याङ्कन *ETF*, *Group Health Insurance Program*, वा तपाईंको रोजगारदातालाई प्रदान गर्ने छैनौं।
* यो कार्यक्रमले तपाईंको डाक्टरको हेरचाह साट्दैन। स्वास्थ्य जाँच र मूल्याङ्कनहरूले समस्याहरू पत्ता लगाउँदैनन् वा उपचाहरूको सल्लाह दिँदैनन्। आफ्नो स्वास्थ्यको बारेमा सधैँ आफ्नो डाक्टरसँग कुरा गर्नुहोला।

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.

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