PLAN YEAR 2018 – NEW ENROLLEE
VALID ONLY – OCTOBER 15, 2017 – DECEMBER 15, 2017

In order to receive a discount on Group Health premium rates for 2018, this form must be returned by DECEMBER 15, 2017.

AFFIDAVIT OF ANNUAL PERSONAL HEALTH ASSESSMENT

Patient's Printed Name:_____ Date: _____

The intent of this affidavit is to confirm that a PERSONAL HEALTH ASSESSMENT was conducted for the above named individual during October 15 – December 15, 2017.

Health Care Provider – we do not require the test results, we only need to know that the assessment was completed.

Personal Health Assessment Elements

- ☐ **Blood Pressure**
- ☐ **Height / Weight**
- ☐ **Complete Metabolic Panel (CMP 14)**
- ☐ **Lipid Panel with TC: HDL Ratio**

_____ _____

SIGNATURE OF HEALTH CARE PROVIDER **PRINTED NAME OR STAMP OF HEALTH CARE PROVIDER**

I, the undersigned City employee/spouse, hereby certify that I have fulfilled the above requirements in order to receive a discounted premium rate for City of Midland offered medical coverage.

_____ _____

Signature of Patient (Employee/Spouse) **Date**

_____ **Employee ID: _____**

Print Name of City Employee
Primary Insurance Holder