PLAN YEAR 2019

HEALTH & WELLNESS PROGRAM

In lieu of completing a Personal Health Assessment through on-site events in the month of May, employees and/or covered spouses may complete this form with their physician. If this form is used, it must be returned to Human Resources no later than June 15, 2018 in order to receive the monthly incentive for 2019 group health premiums.

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 the 2018 calendar year.

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

_____ Printed Name of City Employee (Primary Insurance Holder)

Employee ID: _____