**[Company or Wellness Program Name] Wellness Track for [Year]**

Complete the form below to be eligible for the [discount/incentive] for the [year] plan year. Each tier will earn you the reward listed for the [year] benefit year. Complete all three tier requirements and [earn a total of $\_\_/month ($\_\_\_ annually) insurance premium surcharges waived] in [year]. Please submit this form (with required documentation) to [human resources] by [date].

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Tier 1 | Wellness Activity | Completed | Requirements | Deadline | Reward |
| Tobacco/nicotine-free or completed a tobacco/nicotine cessation program |  | Tobacco/nicotine cessation program and/or tobacco/nicotine attestation | [date] | $\_\_/month ($\_\_\_ annually) premium surcharge waived |
| Tier 2 | Wellness Activity (choose 3) | Completed | Requirements | Deadline | Reward |
| 1. Biometric screening
 |  | Participate in onsite screening event or complete the physician screening form | [date] | $\_\_/month ($\_\_\_ annually) premium surcharge waived |
| 1. Annual physical
 |  | Preventive exam form signed and dated |
| 1. Dental exam
 |  | Preventive exam form signed and dated |
| 1. Vision exam
 |  | Preventive exam form signed and dated |
| 1. Flu shot
 |  | Preventive exam form signed and dated |
| 1. Recommended preventative exam'(mammogram, colonoscopy, etc.)
 |  | Preventive exam form signed and dated |
| Tier 3 | Wellness Activity (choose 3) | Completed | Requirements | Deadline | Reward |
| 1. BCBSKS nurse coaching program (weight management, stress, diabetes, hypertension, etc.)
 |  | Certificate of completion/participation | [date] | $\_\_/month ($\_\_\_ annually) premium surcharge waived |
| 1. Fitness center attendance (\_\_ times between [date] and [date])
 |  | Proof of attendance |
| 1. Attend four education lunch and learns
 |  | Proof of attendance |
| 1. Participation in two physical wellness challenges (walking stairs, physical activity, etc.)
 |  | Proof of participation |
| 1. Participate in two community activity events (5k, bike event, walk/run, etc.)
 |  | Proof of participation |
| 1. Participation in a recreational/sports league (soccer, softball, volleyball, etc.)
 |  | Proof of participation/completion |
| 1. Donate blood
 |  | Proof of participation |
| 1. Use a resource from the EAP (read an article, complete an online training course, visit with a counselor), sign up for Amwell app (telemedicine), etc.
 |  | Proof of participation |

I verify the information on this form is complete and accurate to the best of my knowledge. I understand that my participation on this form will be used to determine eligibility for [company or wellness program name] in [year]. I understand that if any information is misrepresented on this form, I may be subject to penalties.

Employee signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Participation in the wellness program is voluntary and does not impact employment. If you have trouble completing activities, please contact:*

*[HR or contact person and information]*