We are pleased that you are participating in the health screening this year. Participation in the health screening is confidential. Please review these instructions to ensure that your information is complete and sent to the correct location.

To complete your health screening with your provider:

1. Call your provider to schedule an appointment for an annual preventive screening.
2. Fill out the Participant Information section of the Data Form. (If you are not familiar with your employee ID, please contact your local HR representative.)
3. At your appointment, give the Data Form to your provider, and instruct the provider to fill out the Screening Results section of the form.
4. Screenings completed on or after January 1, 2017 may used to complete the Data Form. Your physician must sign the form and fax the completed form by October 31, 2017 to:

Wellness Corporate Solutions
Attn: Information Management
SECURE FAX: 1-877-282-2408

Additional Health Screening Information:

- All health screenings must be completed by October 31, 2017 to be eligible for the Company HSA contribution. You are required to complete both the online Health Assessment and submit a completed Data Form with your screening results in order to receive the contribution.
- Simplot Medical Program participants who are covered through COBRA are not eligible for the Company HSA contribution for completion of a Health Screening and Health Assessment.
- The measurements required on the Data Form are included in an annual preventive exam, the cost of which is covered 100% by the Simplot Medical Program when you go to an in-network provider. Be sure your provider codes your visit as preventive. If your provider performs additional tests or services that are not covered as preventive services, you will be responsible for the additional cost incurred.

Note: In order for this form to be considered complete, your provider must include measurements for height, weight, BMI, blood pressure, fasting status, total cholesterol and glucose on the following page. You are also required to include the date of your screening, as well as your signature and your provider’s signature.

The Employee ID # needed on this form is your 8 character Simplot employee ID + your 8 character DOB (YYYYMMDD). If you are the spouse of a Simplot employee, you will need to use the employee’s 8 character employee ID + your own 8 character DOB.

If you have any questions please contact customer service by emailing simplot@livehealthier.com or calling (844) 554-9910.
DATA FORM FOR HEALTH SCREENING WITH YOUR PERSONAL PHYSICIAN

PARTICIPANT: Complete Participant Information, bring form to provider for completion.
Retain a signed copy for your records.

PROVIDER: Complete Screening Results and sign the form.
FAX completed form by October 31, 2017
TO Wellness Corporate Solutions at 1-877-282-2408

I understand that the purpose of my health screening is to evaluate my health status and any potential health risks. I hereby request and authorize Wellness Corporate Solutions, LLC to transmit health information about me to the health management companies that provide services to my employer so that these companies may help me reduce, manage or control any such risks. I understand that Wellness Corporate Solutions, LLC is not responsible for diagnosing, treating, or preventing any medical disease or condition that I currently have or may have in the future. I also understand that Wellness Corporate Solutions, LLC will not give me medical advice and that I must seek such advice from my own physician. I understand that Wellness Corporate Solutions, LLC will not provide my employer any health information that identifies me. I acknowledge and agree that Wellness Corporate Solutions, LLC may provide my employer aggregate statistical health information which includes my health information. I understand that Wellness Corporate Solutions, LLC may also use my health information for its own internal business purposes such as to develop future wellness programs. Finally, I understand that I may faint, bruise, or have other effects as a result of my blood being drawn. I voluntarily agree and consent to participate in the health screening and accept and assume all risks associated with such participation. I hereby release and forever discharge Wellness Corporate Solutions, LLC and its owners, employees, and agents from any and all claims, demands, actions, and damages, including attorney’s fees and costs, arising out of or in any way related to my participation in the health screening. By proceeding with this voucher, the participant acknowledges they have read the “Notice and Consent for Participation” and are aware of their rights and obligations relating to their participation in their Wellness Plan, including but not limited to the participant’s rights related to what information is collected, who will receive it, how it will be used, and how it will be kept confidential.

PARTICIPANT INFORMATION (TO BE COMPLETED BY THE PARTICIPANT)

NAME
FIRST NAME (REQUIRED)

DATE OF BIRTH (REQUIRED)

GENDER (REQUIRED)
Male
Female

PHONE NUMBER

EMAIL ADDRESS

PARTICIPANT SIGNATURE (REQUIRED)

I, the above named participant, have read, understand and agree to the terms and conditions printed at the top of this form. No attempts to modify or amend this form will change such terms or in any way be binding upon Wellness Corporate Solutions.

SCREENING RESULTS (TO BE COMPLETED BY THE PHYSICIAN OR HEALTH PROFESSIONAL)

ALL DATA MUST BE PROVIDED BELOW USING PRE-DEFINED FIELDS
ATTACHMENTS WILL NOT BE REVIEWED OR PROCESSED

SCREENING DATE (REQUIRED)

HEIGHT (without shoes)

WEIGHT (without shoes)

BMI

WAIST

BLOOD PRESSURE

PULSE

FASTING STATUS (REQUIRED)

TOTAL CHOLESTEROL

HDL CHOLESTEROL

LDL CHOLESTEROL

TRIGLYCERIDES

GLUCOSE

NOTES:

PLEASE FAX FORM ONLY ONCE, AFTER COMPLETING ALL TESTING.

PHYSICIAN SIGNATURE (REQUIRED)

PHONE NUMBER (Provider/Clinic)

PLEASE FAX COMPLETED DATA FORM TO: WELLNESS CORPORATE SOLUTIONS, SECURE FAX: 1-877-282-2408