Immanuel

Physician Medical Waiver

Dear Physician,

As a company that cares about the health and wellness of our employees, Immanuel encourages all of its employees to take an active role in managing their health and knowing their health risks.

Employees who enroll in Immanuel's health insurance coverage are able to receive a wellness reward contribution into their health savings account by participating in certain events throughout the year. The biometrical screening is one of the requirements that will to be completed in order to receive this wellness reward.

The screening consists of the following:

- Blood pressure measurement
- Waistline measurement
- Height & Weight to calculate BMI
- A fasting blood draw which measures triglycerides, HDL cholesterol and blood glucose

If, due to a medical condition, it is medically inadvisable or unreasonably difficult for your patient to participate in the screening, please complete this affidavit and the patient will receive a waiver for screening requirements. For example, pregnant women do not need to participate in the screening to receive the credit.

Please review this waiver carefully, attest to the appropriate information and then sign and date the form at the bottom. The patient (Immanuel employee) must also sign and date the form. Completed forms must be faxed to (402) 939-0458, or mailed to TotalWellness no later than August 18, 2017.

For verification your form was received, please provide an email. If no email is available and you would like to verify your form was received, please contact Data Support at 402-964-0542 ext.127.

The information that you provide on this form will be kept confidential by TotalWellness and Wellworks For You and will not be used for any purpose other than to determine if the patient is eligible for a waiver of the screening.

As the patient's treating physician, I hereby attest that it is medically inadvisable or unreasonably difficult due to a medical condition for the patient below to participate in the biometrical screening.

Physician Name (Print) _____

Physician Signature _____ Date _____

By signing this form, I verify that the information supplied here is accurate and complete.

Employee First Name (Print) _____

Employee Last Name (Print) _____

Date of Birth (MM/DD/YY) _____

Employee Signature _____

Employee ID_____

Date _____ Phone Number _____

Email address _____

Please ensure all fields above are completed.

Please fax this form to: (402) 939-0458
or
Mail to TotalWellness: Attn: Data Team, 9320 H Court, Omaha, NE 68127