IB13

State Employees' Insurance Board

Revised 8/12

Provider Screening Form

Instructions: If you cannot or choose not to participate in SEIB's Worksite Wellness screenings, you may submit your health screening results through your physician. You are to complete Section 1 of the form and your provider is to complete Section 2. In order to be eligible for the wellness premium discount, this form should be returned to the SEIB no later than 60 days of date of hire. Refunds are not allowed.

SECTION 1 (To Be Completed by Employee)

Member Name (Please print)	**Screening Date**	**Male** ☐ **Female** ☐	**Age:** _____
Contract Number	**Social Security Number**	**Date of Birth**	**Day Time Phone Number**
E-Mail Address			

What best describes your race/ethnicity?

☐ White ☐ Black/African American ☐ Asian ☐ Indian or Alaska Native

☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ Other

Do you have (or have you been told you had) any of the following? (Mark all that apply.)

☐ High Cholesterol ☐ High Blood Pressure ☐ Diabetes

Do you take Medication for any of the following? (Mark all that apply.)

☐ High Cholesterol ☐ High Blood Pressure ☐ Diabetes

SECTION 2 (To Be Completed by Provider)

Blood Pressure _____ / _____	
Total Cholesterol_____ mg/dL	**Height _____ft. _____ in**
HDL Cholesterol _____ mg/dL	**Weight _____**
LDL Cholesterol _____ mg/dL	**BMI _____**
Triglycerides _____ mg/dL	**Waist/Ht Ratio _____**
Blood Glucose _____ mg/dl	

Provider's Name: (Please print) _____

Provider Signature: _____

Provider Address: _____

Please return completed form to:
STATE EMPLOYEES' INSURANCE BOARD
P O BOX 304900
MONTGOMERY AL 36130-4900
1.866.838.3059 FAX: 334.517.9980