State Employees' Insurance Board
State Employees' Health Insurance Plan
Wellness Discount Certification Form

Member Name (Please print)		Male ☐ Female ☐	Age:
Contract Number	**Social Security #**	**Date of Birth**	**Day Time Phone Number**

I have participated in a worksite wellness screening and one or more of the following health risk(s) have been identified.

- blood pressure systolic reading of 160 or higher, or diastolic reading of 100 or above;
- total cholesterol reading equal to or above 250;
- glucose reading equal to or above 200;
- body mass index equal to or above 35.

Regardless of your identified health risk(s), you can qualify for the wellness premium discount by certifying that you have completed one of the requirements below;

☐ I was counseled by my healthcare provider regarding the health risk(s) identified in my wellness screening results and I have attached one of the following:

   ☐ Wellness Program Office Visit Referral that has been signed by my healthcare provider, or

   ☐ Completed Provider Screening Form documenting my results.

☐ I participated in at least 12 weeks of a 15-week Weight Watchers program.
   Location of program _____
   Date(s) I attended   _____

☐ I participated in a YMCA wellness program.
   Location of program _____
   Date(s) I attended   _____
   Program description _____ (i.e.: aerobics)

☐ I am self-managing my identified health risk(s). Attached is *valid proof* that I have made improvement in my identified health risk(s). **NOTE:** you must have made improvement in all identified risk(s) in order to continue your discount.

This information must be received in our office no later than November 30. Incomplete forms will be returned.

> **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**