FOX VALLEY TOOL & DIE

Due to Human Resources by November 30, 2024 to earn premium contribution for 2025

2024 Wellness Statement

IMPORTANT: Use this form if you plan to have your primary care provider indicate that you are in compliance with the required preventive screenings to participate in the Fox Valley Tool & Die wellness program.

SECTION 1. – TO BE COMPLETED BY HEALTH PLAN PARTICIPANT

Step 1: Please complete all information below:

Employee Name:_____**Email:**_____**Employee No:**_____
(Employee that carries plan coverage) *(please print)*

Participant Name: _____
(Either Employee or Spouse) *(please print)*

I am a *(check one box)*: ☐ Employee ☐ Spouse Participant

Step 2: Participant Authorization

I am participating in the Fox Valley Tool & Die Wellness Program and hereby authorize my dentist/primary care provider's office to complete this document on my behalf in order to receive FVTD's wellness benefit for 2025. **I also acknowledge that it is my responsibility to ensure my Wellness Statement is completed by my Provider's office and is received by HR by 11/30/2024. **If there is an extenuating circumstance that requires your physical or teeth cleaning in December of 2024, please talk to HR to give them advance notice your form will be late.** *Please sign and date below, and continue to Step 3.*

Step 3: Forward or bring this form to your dentist/primary care provider's office for completion. **No appointment is needed if you are up- to-date with the preventive screenings in Section 2 below.** *Form may also be completed by an OB-GYN or other specialist.*

- **Please request and keep a copy** of your completed Wellness Statement for your records**.**
- **You are responsible to ensure your Wellness Statement is completed by your Provider's office and is received by November 30, 2024.**

SECTION 2. – TO BE COMPLETED BY DENTIST/PRIMARY CARE PROVIDER'S OFFICE

Please fill out to indicate participant achievement:

Physical Exam(s): *Annually for all men and women*

Signature of Provider's Designee:

Name_____ Signature_____ Date_____
(please print)

Dental Exam/Cleaning: *One annual dental cleaning and exam*

Signature of Provider's Designee:

Name _____ Signature_____ Date_____
(please print)

Office use only:
Date received:_____ Initials_____

Form may be faxed to 920-766-9135, attention HR