City of Corpus Christi Wellness Incentive - Physician Statement

*****Complete a preventive wellness exam and return this completed document to Human Resources - Benefits BEFORE September 20, 2019.*****

Name: _____ Department: _____

Employee ID: _____ Phone Number: _____

Please acknowledge your understanding of the following:

☐ I understand that I am responsible for completing a preventive wellness exam and obtaining the providing practitioner's signature below to earn my wellness incentive. The City provides 5 options for earning the wellness incentive but as of July 31, 2019 this is the last remaining option to earn the incentive for FY 2020.

☐ I understand that it is my sole responsibility to complete this form and turn it in Human Resources **before September 20, 2019** to earn my wellness incentive for October 1, 2019 – September 30, 2020. **To receive the incentive, I must remain enrolled in the Citicare Medical Plan. If I drop the Citicare Medical Plan, I am no longer eligible for the incentive.**

☐ I understand that if I do not complete this form and turn it in by the date above, I will not be eligible to receive the wellness incentive until the *following* plan year, October 1, 2020 – September 30, 2021.

_____ _____

Employee Signature Date

Must be Authorized by providing Physician to be valid

Physician verification:

☐ I verify I performed a preventative wellness exam on the individual listed above on _____
(Date)

_____

Physician Name Phone # Location

_____ _____

Physician Signature Date

Office Use Only: Verified Coverage_____ INFOR Entry _____ Scanned _____ Laserfiche Verified _____