CITY OF FORT LAUDERDALE – BENEFITS SECTION

WELLNESS INCENTIVE PROGRAM PHYSICIAN VERIFICATION FORM

ELIGIBLE EMPLOYEES ENROLLED IN A CITY MEDICAL PLAN AS A DEPENDENT (SPOUSE/DP) OF ANOTHER CITY EMPLOYEE

Rev: 2 | **Date:** 12/15/2023 | **Print Date:** 12/15/2023

This form is for use by Eligible Employees participating in the City's Wellness Incentive Program (WIP) who are enrolled in one of the City's Medical Plans as a dependent (spouse/domestic partner (DP)) of another City Employee.

Instructions:

1. **Please complete the top portion (PART 1).**
2. **Have your physician/practitioner complete the wellness program activity verification section (PART 2) to certify that the service(s) indicated below have been completed.**
3. **Submit this completed form along with your completed Wellness Incentive Program Tracker form (PART 3) to the City's onsite Well-Being Coordinator, Adam Clawson by December 31 to receive your WIP payout in accordance with the eligibility rules and conditions. Both Forms must be completed and received by December 31.**

PART 1. To be completed by Employee:

ELIGIBLE EMPLOYEE NAME COVERED AS SPOUSE/DP (PRINT)	EMPLOYEE ID #	DATE OF HIRE/PROMOTION
EMPLOYEE NAME THAT HAS PRIMARY MEDICAL COVERAGE (PRINT)	**EMPLOYEE ID #**	

PART 2. Wellness Program Activity verification to be completed by Physician/Practitioner:

I hereby confirm that the above reference employee (please check all completed services):

CHECK ALL COMPLETED SERVICES	PROGRAM ACTIVITY COMPLETED	DATE COMPLETED
	Completed an Annual Physical (Preventive Exam)	
	Completed a Biometric Health Screening that included: • a blood pressure check, • cholesterol screening, • a blood glucose/blood sugar screening, • and a measurement of height and weight.	
	Got a Flu Shot	
	Completed a Mammogram	
	Completed a Prostate-specific antigen (PSA) screening	
	Completed a colon cancer screening (colonoscopy)	
	Completed an OB/GYN Exam	
	Completed a Cervical cancer screening	

Please affix the provider's official stamp on this completed document prior to submission.

_______________________________ Print Name of Health Screener

_______________________________ Signature of Health Screener

_______________________________ Telephone Number

_______________________________ Date

Part 3. Submit Forms:

Please email this completed form along with your completed Wellness Incentive Program Tracker form to Adam.Clawson@CignaHealthcare.com
OR Fax: 954-867-5583
Attention: Adam Clawson
Phone: 689-231-8035

Approved by: Jerome Post, Director of Human Resources
Uncontrolled in hard copy unless otherwise marked

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