5250 S Sixth St Frontage Rd E
Springfield, IL 62703
hope.us

P 217.585.5437
F 217.529.8234

Wellness/Preventative Care Visit Affidavit

To receive the wellness incentive, health care provider must sign and date where indicated below. New employees must return this form to Human Resources within 60 days of enrollment to receive the premium differential for the remainder of the current plan year.

Name_____Date of Birth_____

☐ I am an employee of Hope

☐ I am a spouse of an employee at Hope (Employee's Name___ _____)

To be completed by Provider

If service was rendered, please check the appropriate box and list completion date

☐ Wellness Exam Date of Exam _____

☐ Biometric Screen Date Completed _____

Biometric Screen parameters: height, weight, BMI, blood pressure, cholesterol test, & glucose test

Please do not include any results or findings of Exam/Screening

_____ _____

Provider Signature **Date**

I certify that the information provided above is true and correct, and able to provide additional proof of completion of Wellness Exam and Biometric Screen if requested.

_____ _____

Employee/Spouse Signature **Date**

Form may be Faxed to 217-529-8234 or emailed – Attention: Orietta Moore
omoore@hope.us