2025 Physician Form

Instructions:

1. Complete **all** participant information, including employee ID or Spouse ID, email, and sign the form.
2. **Visit your health care provider for a Health Screening, print and take this form to your appointment. The cost of the lab tests listed on this page will only be covered if included as part of an annual preventive wellness exam.**
3. Ask your provider to complete the Health Screening Information section using results obtained between 1/1/2025 and 9/30/2025 and **sign the form**.
4. Submit form once, using one method listed below. **Forms must be received by 9/30/2025**. **Forms received after the deadline will not be accepted.**
   a. Securely upload (preferred method) online at www.LIIvewell.com
   b. Fax securely to 402-939-0772.
   c. Mail to TotalWellness, Attn: Data Team, 9320 H Court, Omaha, NE 68127. **Forms must be received by 9/30/2025**; please allow time for mailing.

It is your responsibility to make sure that your form is submitted by the deadline.

5. Within 48 hours of form submission, a confirmation email will be sent to the email listed below. If a confirmation email is not received within 48 hours, please resubmit your form.
6. Please allow 10 business days for the information to be available on www.LIIvewell.com.

PARTICIPANT INFORMATION

Participant First Name:

Participant Last Name:

Participant Date of Birth: (mm/dd/yyyy) / /

Employee ID/Employee ID +Spouse DOB (EX: 12345MMDDYYYY):

Email: (Required to provide confirmation of form receipt.)

Gender:	O Male	O Female
Have you fasted for at least 9 hours? (*No food. Only water & prescribed medications permitted.)*	O Yes	O No
Are you pregnant? *(Females Only)*	O Yes	O No

If 'Yes' please fill out Pregnancy Waiver form and submit it by **11/28/2025

HEALTH SCREENING INFORMATION

Date of Screening: (mm/dd/yyyy) / /
(Acceptable Date Range: 1/1/2025 – 9/30/2025)

Blood Pressure: /
Systolic / Diastolic

Height:
Ft. / Inches

Weight:
Lbs.

Waist:
Inches

Glucose:

Total Cholesterol:

HDL:

LDL:

Triglycerides:

BMI: .

Physician Printed Name: _____ Physician Phone Number: _____

Physician Signature (required):_____

CONSENT

Disclosure of Information. I understand that the information submitted on this form (my "Personal Information") will be transferred to WebMD by TotalWellness. My Personal Information is used by WebMD to provide wellness program services to me, which includes using the Personal Information to inform me of relevant health related and health education programs offered by WebMD or by another service contractor. In the event that WebMD's services are transitioned to another service provider, WebMD may deliver my Personal Information to the successor provider to maintain a continuity of services for me. In order to distribute any incentives, WebMD may provide my name/unique ID to my employer or its designated representative to notify them of the fact that I am eligible for the incentive. In addition to any Personal Information disclosed as set forth above, aggregate, de-identified survey results may be made available to my employer for program administration purposes. WebMD may also use my Personal Information as part of group statistical research and analysis, in a manner that does not identify me. I also understand that my Personal Information may be incorporated into my online Wellness Assessment results by WebMD. Except for these types of usage and the uses specified in my WebMD Online terms of use, and Privacy Policy, available under the "Policies" link at the bottom of the page at the following www.LIIveWell.commy Personal Information will not be disclosed by WebMD. WebMD understands that Personal Information may be considered protected health information that is subject to the privacy and security rules of the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"). WebMD will comply with the HIPAA to the extent applicable.

GINA Notice and Authorization. This Health Screening is part of my employer's wellness program ("Employer Program"), which is a voluntary wellness program administered according to federal rules, including the Genetic Information Nondiscrimination Act ("GINA"). The results of this Screening may be considered GINA Protected Information. GINA requires that you receive this GINA Notice and Authorization prior to undergoing the Screening. Your Employer Program uses GINA Protected Information to help you understand your potential health risks and to offer you other wellness program services. The Employer Program safeguards GINA protected information and will not disclose any GINA Protected Information, except as permitted by GINA and other applicable law. Your GINA Protected Information will be disclosed to you and to vendors of your Employer Program, for purposes of providing you with Employer Program services. Your GINA Protected Information will not be sold, exchanged or transferred, except to the extent required by law to carry out activities related to the Employer Program. You will not be asked to waive the confidentiality of this information as a condition of participating in the Employer Program or as a condition of receiving any incentive. Your GINA Protected Information will only be disclosed to your employer in aggregate terms that do not disclose your specific identity.

Certification: I certify that the information supplied on this form is accurate and has been provided by me by my health care provider.

Participant Printed Name: _____ Date: _____

Participant Signature (required):_____

Submit form using one of the following methods: Securely upload (preferred method) online at www.LIIveWell.com | Fax to 402-939-0772
Mail to: TotalWellness, Attn: Data Team, 9320 H Court, Omaha, NE 68127- **Form must be received by 9/30/2025**