Request for Waiver – Appeal Form

B\Well, Baird's well-being program, encourages associates to complete a Biometric Screening to know your numbers. **If it is medically inadvisable for you to complete the Biometric Screening, you may submit an appeal** for Baird to waive your screening.

1. Please print in dark ink and initial all cross-outs.
2. You **and your provider** must complete and sign this form.
3. Submit your form online at **https://www.totalwellnesshealth.com/gravity-landing/baird-appeal-submission/** or fax to 402-939-0604.
4. You will receive a confirmation email within 48 hours of submission to indicate your form status. If you do not receive a confirmation email within 48 hours, please resubmit your form.
5. Please allow at least 10 business days from submission for your credit to appear in your B\Well account.

Note: You must still complete your Wellbeing Questionnaire by 5 p.m. CT on September 19, 2025.

Section 1: PARTICIPANT INFORMATION		
Name:		**Unique ID:** *Last 4 digits of your Social Security Number*
Street Address:		**City:**
State:	**Zip Code:**	**Date of Birth:**
Daytime Phone: *Area Code First*		**Home Phone:** *Area Code First*

PARTICIPANT VERIFICATION: Appeals cannot be processed without a full signature and date.

By signing this form, I verify that the information supplied here is accurate and complete.

REQUIRED **Participant Signature:**	**Date:** *Between 9/21/2024 – 9/19/2025*

Section 2: PHYSICIAN INFORMATION

As the above participant's physician, I verify that it is medically inadvisable for the individual to complete the Know Your Numbers Screening.

- ☐ Patient is pregnant or postpartum.
- ☐ Patient or spouse/partner is actively participating in a treatment program.

Please provide additional details below.

PHYSICIAN VERIFICATION: Appeals cannot be processed without a full signature, date, printed name, and phone number.

By signing this form, I agree that I have reviewed the above participant's health status and verify that the selected option above is accurate.

Provider Name:	**Provider Phone Number:**

REQUIRED **Provider Signature:**