2026 ITW Health Care Provider Form – New Hire*

Instructions:

1. Complete all participant information, including email.
2. Visit your health care provider for a health screening and take this form to your appointment to be completed by your physician.
3. Submit the form once, using one of the methods listed below:
   a. Securely upload online at **https://www.totalwellnesshealth.com/gravity-landing/itwnewhire/ (recommended)**
   b. Fax securely to 402-939-0604. IMPORTANT NOTE: Keep a copy of your successful fax transmission confirmation page.
4. 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.
5. Please allow 10 business days for the information to be available on the Living Well at ITW wellness portal.

Deadline to submit the Health Care Provider Form:

a) As a new hire (*hired on or after 6/2/2026), this completed form must be received by 4/30/2027 – Exam dates must be: 1/1/2026-4/30/2027.
b) Forms received after the above deadline will not be accepted.

It is the employee's responsibility to make sure this form is submitted and received by the deadline. Preventive services are covered at 100% in-network, but the employee is responsible if a copayment is charged. Contact your provider to verify coverage and cost prior to your visit.

PARTICIPANT INFORMATION

Participant First Name:

Participant Last Name:

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

Employee ID:

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

Have you fasted for at least 9 hours? *(No food. Only water permitted.)* O Yes O No

Are you pregnant? *(Females Only)* O Yes O No

HEALTH SCREENING INFORMATION

Date of Screening: (mm/dd/yyyy) / /

Blood Pressure: / (Systolic / Diastolic)

Height: (Feet / Inches)

Weight: (Pounds)

Waist: (Inches)

Glucose:

Total Cholesterol:

HDL:

LDL:

Triglycerides:

Physician Printed Name: _____ Physician Phone Number: _____

Physician Signature: _____

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 Health 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 at http://www.webmdhealth.com/itw respectively, my 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.

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

Participant Signature (required) _____ Date (required) _____

Submit form using one of the following methods:
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