State of Rhode Island Rewards for Wellness Program

BMI Co-Share Incentive Form

Eligible employees* have the following options to qualify for the BMI co-share incentive credit:

1. If your BMI is **below** 30, then screening can be completed at Health Fair **or** physician's office.
2. If your BMI is 30 or over or if you do not want your BMI screened, then complete one of the following to qualify for $50 co-share incentive credit:
   - Enroll in an approved weight loss program, such as Weight Watchers **OR**
   - Submit proof of gym membership **showing that you have enrolled in a gym membership between the incentive offer beginning on 11/2/15 through 3/31/15 and the membership must be at least three months during the incentive offer (11/2/15-3/31/16) OR**
   - Attend 3 visits with an in-network nutritionist/dietician (no co-payment if BMI ≥30).

*All State of RI employees are eligible to participate in Rewards for Wellness Activities, but only employees who are paying State employee medical co-shares posted at www.employeebenefits.ri.gov are eligible to receive incentives for co-share credit.

Name (please print): _____ DOB: _____

Contact Phone Number: _____

UHC Subscriber/Member ID (on UHC card) OR SSN: _____

… For BMI **under** 30, request your physician fill out the following information if you did not obtain a BMI screening at a health fair:

_____ Date of Physician Screening Height _____ft _____ in Weight _____ lbs

Body Mass Index (BMI): _____

Physician's Signature: _____ Date: _____

Name of Physician (please print): _____

Physician Address/Telephone: _____

In accordance with HIPAA, no personal health information will be shared with the State of Rhode Island.

OR

… Attach copy of receipt showing enrollment in Weight Watchers or an approved weight loss program.

OR

Attach copy of receipt(s) showing **three-months of gym membership any time from 11/2/15 to 3/31/16.**

Name of gym: _____

OR

… List dates of visits and name of in-network Nutritionist/Dietician for verification through UHC system.

1. _____ 2. _____ 3. _____ Name of Nutritionist _____

Employee must mail/fax this form and any necessary documentation by April 1, 2016 to:

Linda McCormick
UnitedHealthcare
475 Kilvert Street Warwick, RI 02886

Fax Number: **401-732-7211**
Please keep a copy of your fax confirmation for proof of submission.

For more details, please go to www.wellness.ri.gov.

UnitedHealthcare