

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 3/31/16 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 \geq 30).

*All State of RI employees are eligible to participate in Rewards for Wellness Activities, but only employees who are paying State employee medical es-shar 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.

