# Important Instructions

**Use this form when participating in the Wellness Program outside of an on-site scheduled Biometric Screening such as your Primary Care Physician (PCP).**

It is REQUIRED to complete the 1st page of the Health Screening Program Consent and Authorization form, which includes two signatures. The next 2 pages of the Health Risk Questionnaire is optional. However, it is preferred that you complete the Questionnaire as well.

Provide your portion of the completed required forms and the Primary Care Physician (PCP) form to your physician at the time of your office visit. Your physician will need to complete the PCP form and provide **ALL** your biometrics indicated on the form. **ALL required** forms must be faxed together to Healics. You will find Healics' contact information on the bottom of the PCP form.

Please keep in mind, it is your responsibility to provide ALL forms to Healics for processing. You should request a copy of the completed form from your physician to keep for your records. If within 1 month of your doctor's visit you do not receive in the mail your Healics Health Report, please contact Healics at 414-375-1600 or 800-432-5427 or email them to hraprocessing@healics.com Begin by providing specific information including the name of the Health Fund, your name and the date of your office visit or when the forms were faxed.

Thank you

CASE MANAGEMENT SPECIALISTS, INC.

# Health Screening Program
# Consent and Authorization

Barcode

The purpose of this voluntary health screening program offered through your employer is to gather sufficient information, so you can receive an informative confidential Healics™ Health Report from Healics Inc. ("Healics").

**Employer:** **Wisconsin Laborers Health Fund**

Have you participated in a Healics health screening before? ❒ Yes ❒ No

Please print name:_____ Date of birth:_____
(Last Name) (First) (MI) (mm|dd|yyyy)

Mailing address:_____ City:_____ State:_____ Zip:_____

Best contact number:(_____)_____ Work phone number:(_____)_____

Gender assigned at birth: ❒ Male ❒ Female Gender you identify with: ❒ Male ❒ Female ❒ Other

Regarding the sponsor employer, are you the: ❒ Employee ❒ Spouse of employee

If you are a spouse, what is the employee's name? _____

If you are the employee and the sponsor employer has multiple shifts, which shift do you work? ❒ 1st shift ❒ 2nd shift ❒ 3rd shift

I wish to participate in this voluntary health screening offered by the sponsor employer and conducted by Healics. I understand that Healics is the program vendor and it subcontracts with others, such as examiners (to take measurements and to draw blood via venipuncture or fingerstick methods) and lab vendors (to analyze the blood sample).
**I understand the health screening program, including any possible consultation or follow-up, is not a substitute for a full examination by my own primary care provider. I will arrange any appropriate follow-up examinations.** The health coaching process that may be included is a support system, which utilizes goal setting, identification of obstacles and action planning to improve physical health. All information provided in the coaching sessions are suggestions. All suggestions should be cleared with your primary care provider before implementing. I understand that there are possible risks associated with venipuncture or fingerstick methods including, but not limited to, risk of infection, discomfort, bruising and, in unusual situations, more serious risks (including death). I agree that Healics is not liable for such risks when Healics is acting properly, and that I will assume the risk of injuries, including death, damages or loss, which I may sustain as a result of my participation in the health screening. I consent to the taking of blood from me by a qualified examiner. **I understand that I may refuse to sign this Consent, but if I do so, I will not be processed as a participant in the health screening program.** I understand that Healics and its vendors generally are required by law to maintain the confidentiality of the medical information I provide through the health screening. The medical information includes my biometric results and other information about the manifestation of a disease or disorder. Healics uses this information to provide services to me and / or my spouse, such as an analysis of certain health risk factors. Healics is restricted by privacy law in how my or my spouse's medical information can be used or disclosed. For example, the Genetic Information Nondiscrimination Act generally prohibits Healics from disclosing to my employer my spouse's genetic information (which generally includes his or her health status). Such spousal information generally cannot be made available to managers, supervisors or others at the employer who make employment decisions, or anyone else in the workplace. Healics has established privacy and security policies and procedures that discuss how my medical information will be properly held, used and disclosed. I knowingly and voluntarily provide my Consent.

**Signature (required to process results)**: _____ **Date**: _____

If this Consent is signed by a minor or personal representative on behalf of the individual, complete the following:
Personal representative's name and relationship to Individual:_____

I authorize Healics to release my name as a participant, my participation status in the program, and certain other limited health "information" (i.e., my nicotine results and scores) to sponsor employer for the purposes of administering the wellness program. In the event sponsor employer offers a bonus or incentive related to the program, I authorize Healics to release Information to sponsor employer — as well as companies engaged by sponsor employer and/or Healics — for purposes of administering the bonus or incentive related to the program and/or providing me with follow-up coaching, counseling or related services. All other health information resulting from the health screenings will be held confidentially and not shared with sponsor employer. I understand the following:

- **I may refuse to sign this Authorization, but if I do so, I will not be processed as a participant in the health screening program.**
- Sponsor employer may condition my enrollment in a health plan or eligibility for benefits upon my executing this Authorization.
- This Authorization is effective until the earlier of: (1) the date it is revoked or superseded; or (2) one year after the date I signed it.
- I may revoke this Authorization at any time, in writing provided to Healics, Attn: Privacy Officer at 8919 W. Heather Ave., Milwaukee, WI 53224. My revocation will not be effective until received by Healics and will not be effective: (1) regarding any disclosure that Healics has made prior to receipt of my revocation; or (2) if this Authorization was obtained as a condition of obtaining insurance coverage.
- I have the right to request access to health information I have authorized to be used or disclosed pursuant to this Authorization. I may arrange to inspect my health information or obtain copies of my health information by contacting the Healics Privacy Officer at 1-800-HEALICS.
- Information disclosed pursuant to this Authorization may be subject to redisclosure and no longer protected by federal privacy standards.
- A photocopy will be as valid as the original.
- If a disclosure is required by law (e.g., pursuant to a judge's written order), Healics or its representative may be required to make the disclosure.
- I may request a copy of this Authorization.

**Signature (required to process results)**: _____ **Date**: _____

If this Authorization is signed by a minor or personal representative on behalf of the individual, complete the following:
Personal representative's name and relationship to Individual: _____

This constitutes stand-alone documents that are separately: (1) a consent form; and (2) an authorization to disclose health information. Any other documents which are attached to this document are done so for your convenience, in order to ensure that the documents are not misplaced. Please proceed to the attached or following documents and complete the questions. If your primary care provider has prescribed any medication, you must stay on that medication for the health screen.

## 1 Medical History

| Condition | Have you ever been diagnosed or treated for any of the following conditions? (check box if yes) | Are you taking prescription medication for any of the following conditions? (check box if yes) |
|---|---|---|
| Allergies | ❒ | ❒ |
| Arthritis | ❒ | ❒ |
| Asthma | ❒ | ❒ |
| Back or neck pain | ❒ | ❒ |
| Blood pressure | ❒ | ❒ |
| Cancer | ❒ | ❒ |
| Cholesterol | ❒ | ❒ |
| Depression/anxiety | ❒ | ❒ |
| Prediabetes | ❒ | ❒ |
| Diabetes (Type 1) | ❒ | ❒ |
| Diabetes (Type 2) | ❒ | ❒ |
| Fibromyalgia | ❒ | ❒ |
| Heart attack | ❒ | ❒ |
| Heart conditions | ❒ | ❒ |
| Heartburn/acid reflux | ❒ | ❒ |
| Irritable Bowel Syndrome/Crohn's | ❒ | ❒ |
| Kidney disease | ❒ | ❒ |
| Liver disease | ❒ | ❒ |
| Lung disease | ❒ | ❒ |
| Lymes disease | ❒ | ❒ |
| Migraine headache | ❒ | ❒ |
| Obesity | ❒ | ❒ |
| Sleep disorder/trouble sleeping | ❒ | ❒ |
| Stroke | ❒ | ❒ |
| Thyroid disease | ❒ | ❒ |
| Other condition(s) | ❒ | ❒ |
| None of the conditions above | ❒ | NA |
| No prescription medications used | NA | ❒ |

## 2 Pregnancy (Females only)

Are you pregnant? No ❒ Yes ❒ | Trimester 1st ❒ 2nd ❒ 3rd ❒ | Pre-pregnancy weight _____

Are you postpartum (0-12 months)? No ❒ Yes ❒ | Delivery date (mm|dd|yyyy) | | | | | | | | |

Lower of pre-pregnancy or postpartum weight _____

## 3 Weekly Exercise

| On average, how many minutes per week do you exercise (excluding work activity), in which your rate of breathing and heart rate increases for a total of 10 minutes or longer? | 150 mins or greater ❒ | 75-149 mins ❒ | 74 mins or less ❒ |
|---|---|---|---|

## 4 Ergonomics

| On average, how many hours per day do you spend: | 9+ hrs | 7-9 hrs | 3-6 hrs | Less than 3 hrs |
|---|---|---|---|---|
| Sitting | ❒ | ❒ | ❒ | ❒ |
| Standing | ❒ | ❒ | ❒ | ❒ |
| Performing repetitive motions | ❒ | ❒ | ❒ | ❒ |

## 5 Sleep

| On average, how many hours a day do you sleep? | 9+ hrs ❒ | 7-9 hrs ❒ | 3-6 hrs ❒ | Less than 3 hrs ❒ |
|---|---|---|---|---|

Do you experience interrupted sleep, sleep apnea, difficulty with quality sleep? No ❒ Yes ❒

## 6 Nicotine

Have you ever used products containing nicotine?

No ❒

I did, but I quit ❒ Quit date (mm|dd|yyyy) | | | | | | | | |

Current nicotine user ❒

I currently use nicotine in the following way(s):

| | |
|---|---|
| Cigarettes ❒ | Electronic cigarettes (vaping) ❒ |
| Cigars ❒ | Nicotine Replacement Therapy (gum/patch/lozenge) ❒ |
| Pipe ❒ | Chew/dip/pouches ❒ |

## 7 Alcohol

How often do you have a drink containing alcohol?

Never ❒ One time per month or less ❒ 2-4 times a month ❒ 2-3 times a week ❒ 4 or more times a week ❒

How many drinks containing alcohol do you have on a typical day?

0 ❒ 1-2 ❒ 3-4 ❒ 5-6 ❒ 7+ ❒

How often do you have six or more drinks on one occasion?

Never ❒ Less than once per month ❒ Monthly ❒
Weekly ❒ Daily or almost daily ❒

## 8 Safety

In the last 30 days, how often have you read/written texts or emails, viewed/responded to social media or watched videos on a phone or electronic device while driving?

Every time I drive ❒ Most of the times I drive ❒ Some of the times I drive ❒ Rarely ❒ Never ❒

In the last 30 days, how often have you been drowsy, dozed while driving or fallen asleep while driving?

Every time I drive ❒ Most of the times I drive ❒ Some of the times I drive ❒ Rarely ❒ Never ❒

## 9 Stress

| Indicate how often the following apply to you: | Always | Usually | Sometimes | Never |
|---|---|---|---|---|
| I feel stress from work issues | ❒ | ❒ | ❒ | ❒ |
| I feel stress from family/personal relationships | ❒ | ❒ | ❒ | ❒ |
| I feel stress from financial concerns/issues | ❒ | ❒ | ❒ | ❒ |
| I feel stress from health concerns/issues | ❒ | ❒ | ❒ | ❒ |

## 10 Emotional Health

| | | |
|---|---|---|
| Over the past two weeks, have you been bothered by thoughts that you want to hurt yourself or have you attempted suicide? | No ❒ | Yes ❒ |
| Do you currently suffer with or have you ever suffered in the past with an eating disorder? | No ❒ | Yes ❒ |
| Have you ever been in a relationship where you were threatened, hurt, or afraid? | No ❒ | Yes ❒ |

National Suicide Hotline: https://suicidepreventionlifeline.org or 1-800-273-8255
National Depression Hotline, Substance Abuse and Mental Health Administration (SAMHSA) Helpline: 1-800-662-4357
National Domestic Violence Hotline: 1-800-799-SAFE (7233) or 1-800-787-3224 (TTY)

## 11 Readiness to Change

How would you like to enhance or improve your quality of life? Please rate your readiness to change using the key below:

| | | | | | | |
|---|---|---|---|---|---|---|
| Nicotine use | 1 | 2 | 3 | 4 | 5 | NA |
| Alcohol use | 1 | 2 | 3 | 4 | 5 | NA |
| Exercise habits | 1 | 2 | 3 | 4 | 5 | |
| Eating habits | 1 | 2 | 3 | 4 | 5 | |
| Stress management | 1 | 2 | 3 | 4 | 5 | |
| Weight management | 1 | 2 | 3 | 4 | 5 | |
| Sleep habits | 1 | 2 | 3 | 4 | 5 | |
| Financial management | 1 | 2 | 3 | 4 | 5 | |

Readiness to Change key:
1 = I don't have a concern, I'm doing well in this area.
2 = I've begun making a positive change in the area, but need to maintain.
3 = I'm ready to start and want more information (may be used for program planning by your employer).
4 = I would like to start, but concerns are holding me back.
5 = I have a problem but I am not ready to make a positive change.
NA = Not Applicable

## 12 Interest Survey

Identify topics of interest to you (this may be used for program planning by your employer).

| | | |
|---|---|---|
| Personal health coaching ❒ | Back/neck health ❒ | Blood pressure ❒ |
| Stretching ❒ | Fitness ❒ | Cholesterol ❒ |
| Financial health ❒ | First aid/CPR ❒ | Wellness Workshops/Presentations ❒ |
| Sleep health information❒ | Men's health ❒ | Nutrition ❒ |
| Nicotine cessation ❒ | Stress management ❒ | Weight management❒ |
| Women's health ❒ | Emotional well-being program ❒ | Employee Assistance Programs ❒ |
| I am already engaging in activities of interest to me outside of my employer ❒ | | I'm not interested in any guidance or resources ❒ |

What would be your preferred method of receiving well-being information (if used for program planning by your employer)?

Email ❒ Printed Material ❒ Online ❒ Onsite activities ❒

## 13 Primary Care Provider

Do you have a Primary Care Provider? No ❒ Yes ❒

| | | |
|---|---|---|
| Have you had an annual physical with your Primary Care Provider in the last 12 months? | No ❒ | Yes ❒ |
| Do you share your health screening results with your Primary Care Provider? | No ❒ | Yes ❒ |

## 14 Dental Care

Do you have at least one routine dental exam visit per year? No ❒ Yes ❒

## 15 Perceived Health

In general, how would you rate your physical health? Excellent ❒ Very Good ❒ Good ❒ Fair ❒ Poor ❒

## 16 Self-Reported Health Measurements

Height: ☐☐ feet ☐☐ inches Weight: ☐☐☐ pounds

**Thank you for completing the Health Assessment!**

## Primary Care Provider (PCP) Form - Biometric Screening

**Wisconsin Laborers Health Fund** is authorizing your patient to have their biometric screening completed at your office with payment through their own insurance.

The following information is needed to meet the requirements of participation in the screening:

**Date of Biometric Results:** _____

**Participant Information and Biometrics (to be completed by PCP)**

| | |
|---|---|
| Name | |
| Date of Birth | |
| Social Security Number | |
| Best Contact Number | |
| Height | |
| Weight | |
| Blood Pressure | |
| Inches around waist at belly button to nearest ¼" | |
| Participant uses nicotine products (Yes or No) | |

**Blood Tests (to be completed by PCP - <u>provide result for ALL tests listed</u>)**

| | |
|---|---|
| Total Cholesterol | |
| LDL Cholesterol | |
| HDL Cholesterol | |
| Chol/HDL Ratio | |
| Triglycerides | |
| Glucose | |

**PRIMARY CARE PROVIDER (PCP) -** contact Healics, Inc. at the number listed below if you have any questions regarding the blood test requirements.

_____ _____

PCP Name (Printed) PCP Signature and Date

**PARTICIPANT -** Mail this form <u>along with the consent/authorization and health assessment questionnaire</u> to:
Healics, Inc., ATTN: HRA Processing Dept
8919 W. Heather Avenue, Milwaukee, WI 53224
OR fax to 414-375-1639

Contact Healics with questions at 414-375-1600 or 800-432-5427

WISCONSIN LABORERS' HEALTH FUND

4633 LIUNA WAY, SUITE 201 DE FOREST, WI
53532-2510 TELEPHONE: 608-846- 1742
TOLL FREE: 800-397-3373

# Consent for Deductible Waiver under the Wellness Program

By signing below, you acknowledge that you are not accepting the Gift Card during the Wellness Year period of 1/1/22 – 12/31/22 and instead are choosing to have your deductible waived under the Health Plan for the Calendar Year 2023. Please note that if married, both the member and spouse must agree and sign to have their deductible waived rather than accept the gift card.

Please check:

Member: ☐

Spouse: ☐

Member SSN: _____

_____
Member's Name (Print)

_____ _____
Member's Signature Date

_____
Spouse's Name (Print)

_____ _____
Spouse's Signature Date

This form ***MUST*** be returned to the Health Fund for processing.

Your Options:

Email it to: wlclaims@bpalja.com
Fax to: 608-846-3224
Mail to: WI Laborers Health Fund, 4633 Liuna Way, Suite 201, Deforest WI 53532

# *WISCONSIN LABORERS' HEALTH FUND*

## What Do I Do After Reading My Health Report?

If you participated at the **on-site Wellness Event** and **opted for the Gift Card** here is what happened: If you MET the acceptable ranges, you received $225. If you DID NOT meet the acceptable ranges, you received $75. If you participated with your **Primary Care Physician**, and do not select to Waive your Deductible the incentives will be paid to you in the form of a check based on your results and the acceptable ranges. If you DID NOT meet the Fund's acceptable biometric ranges, you may participate in health coaching and you would receive the additional incentive(s) based on the incentive option you selected.

- **If you opted for the Gift Card** and participate and complete health coaching, you would be entitled to an additional $150 incentive in the form of a check and a one-time $100 Health Reimbursement Account (HRA) credit.
- **If you opted for the Waiver of your Deductible** and participate and compete health coaching, you would be entitled to a one-time $100 Health Reimbursement Account (HRA) credit.

The $100 credit will be posted to your HRA after the Health Fund receives confirmation that you have completed your coaching. (NOTE: the HRA credit does not apply to Early Retirees). Keep in mind the coaching time frame mentioned below.

Your Healics Risk Level/Score is presented here with corresponding coaching sessions. Your individualized scorecard is based on national standards. We encourage you to speak with your Health Coach and decide how you would like to plan your health goals.

If you meet the acceptable biometric ranges, you are NOT required to do any coaching sessions.

| Risk Level/Score | Coaching Sessions | Total Sessions |
|---|---|---|
| Minimal (86-100) | Report Consultation | 1 |
| Moderate (71-85) | Report Consultation +1 | 2 |
| Medium (61-70) | Report Consultation +2 | 3 |
| High (51-60) | Report Consultation +3 | 4 |
| Extreme (50 or less) | Report Consultation +3 | 4 |

***Health coaching is available to all risk levels; maximum limit of four sessions.**

You should expect to receive a call from a CMS Health Coach within one month of receiving your health report. **If you have significant concerns regarding your health, or one month has passed and you have not heard from a Health Coach, please contact CMS at 262-563-6460. All coaching sessions must begin no later than January 31, 2023 and completed by March 31, 2023.**

*Remember that health and wellness changes are behaviors that occur over time. To achieve the best overall results, take advantage of your health coaching. Not rushing through health and wellness has been shown to be a good recipe for success!*

BeneSys CMS CASE MANAGEMENT SPECIALISTS, INC. Healics With you for life

# Wellness Year 3 (January 1, 2022 – December 31, 2022)

Acceptable Ranges

- Body mass index (BMI) ≤ 27.5kg/m2
- Total cholesterol < 200mg/dL
- Blood pressure ≤ 140/90mmHg
- Non-fasting glucose ≤ 200mg/dL

If you fail the BMI target, you now have the option to substitute your body fat measurement instead. The following shows the normal recommended body fat percentages by gender. You must fall within the applicable range to satisfy the marker.

| **Males** | **Females** |
|---|---|
| 24.9 | 35.9 |

If you fail the Total Cholesterol target, you now have the option to substitute your Total Cholesterol: HDL ratio. The following shows the recommended Total Cholesterol: HDL Ratio by gender.

| | **Males** | **Females** |
|---|---|---|
| Average Risk | 5.0 | 4.4 |

*All telephonic coaching for this period **must begin no later than January 31, 2023**, as the coaching must be completed no later than March 31, 2023. It is your responsibility to plan your coaching sessions ahead of the completion date.*