Activity Authorization Form
Be Well Rewards Program

Medical Professional Instructions

Dear Medical Professional,

*As part of the Be Well wellness program initiative, benefit eligible employees have been asked to participate in various routine **preventative** health visits. The Be Well program is not requesting any records or personal health information pertaining to these visits. Once the corresponding visit is complete, please sign, date, and return this form to our employee, so they may turn it in to the Be Well program as confirmation.*

** Please inform the employee that if other tests/services are performed, the employee may be responsible for out-of-pocket costs based on their insurance plan.*

Sincerely,
Be Well Program

***Please have medical professional print, sign & date this section.**

Using separate copies of this sheet, please have the appropriate medical professional sign off for each visit.

Type of Visit: _____
(Vision, dental, physical, spouse/child, flu shot, *other* preventative screening)

Name: _____
Signature: _____
Date: _____

Employee Information & Release

I_____(print employee name) authorize_____(medical professional's name) to release the dates of my routine physical exam, as specified on this form for the Be Well program.

I understand participation in the Be Well program is voluntary, and that this is for a preventative wellness exam. If other tests/services are performed, I will be responsible for out-of-pocket costs based on my insurance plan.

Employee Name (Print):_____ Employee Signature:_____