2024 HEALTH SCREENING FORM

Heartland Health & Wellness Fund

I am (select one): ☐ a member ☐ the spouse of a member **Questions?** Call Heartland at 937.665.1900.

BIOMETRIC SCREENING

First Name

Last Name

Medical ID#

Last 4 digits of SS#

Email

Telephone

Street Address

City State Zip

I understand this form must be fully completed and legible to be processed. Results must be from a 2024 biometric screening to be eligible. **Please remember to fast 12 hours in advance**. By signing this form, I agree with the health screening results provided. I hereby authorize the medical health care provider and/or medical facility to release the health data to the Fund's wellness and claims analysis providers and the Heartland Health & Wellness Fund.

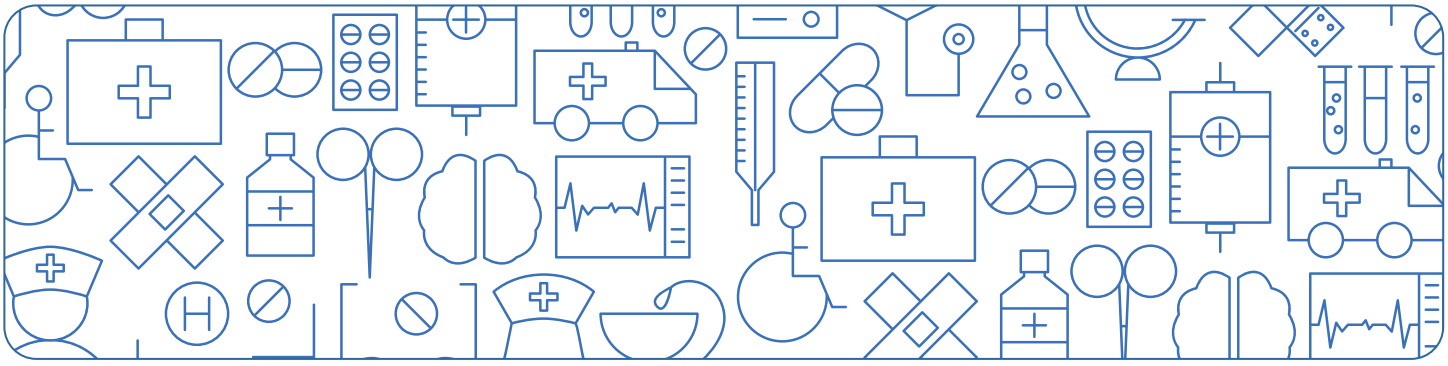
SCREENING TEST	RESULTS	SCREENING TEST	RESULTS	SCREENING TEST	RESULTS
BMI		Blood Pressurel		Total Cholesterol	
HDL Cholesterol		LDL Cholesterol		Triglycerides	
Blood Glucose		Notes:			

(Signature of person screened)

Date of Screening

(Print name of in-network provider)

(Signature of in-network provider)



You are responsible for returning this completed and signed form to the Fund office.

EMAIL	MAIL	FAX
wellness@ufcwbenefitplan.com	Attn: The Wellness Department Heartland Health & Wellness Fund 7250 Poe Avenue, Suite 300 Dayton, OH 45414	937.910.0600