

State Employees' Insurance Board

Provider Screening Form

Instructions: If you can not or choose not to participate in SEIB's Worksite Wellness screenings, you may submit your health screening results through your physician. You are to complete Section 1 of the form and your provider is to complete Section 2. In order to be eligible for the wellness premium discount, this form should be returned to the SEIB no later than 60 days of date of hire. Refunds are not allowed.

SECTION 1 (To Be Completed by Employee)

Member Name (Please print)	Screening Date	Male <input type="checkbox"/>	Age: _____
		Female <input type="checkbox"/>	
Contract Number	Social Security Number	Date of Birth (00/00/00)	Day Time Phone Number ()

What best describes your race/ethnicity?

- White Black/African American Asian Indian or Alaska Native
 Hispanic/Latino Native Hawaiian/Pacific Islander Other

Do you have (or have you been told you had) any of the following? (Mark all that apply.)

- High Cholesterol High Blood Pressure Diabetes

Do you take Medication for any of the following? (Mark all that apply.)

- High Cholesterol High Blood Pressure Diabetes

SECTION 2 (To Be Completed by Provider)

Blood Pressure _____ / _____ Total Cholesterol _____ mg/dL HDL Cholesterol _____ mg/dL LDL Cholesterol _____ mg/dL Triglycerides _____ mg/dL	Blood Glucose _____ mg/dl Height _____ ft. _____ in Weight _____ BMI _____
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Provider's Name: (Please print) _____

Provider Signature: _____

Provider Address: _____

Please return completed form to:
STATE EMPLOYEES' INSURANCE BOARD
P O BOX 304900
MONTGOMERY AL 36130-4900
1.866.838.3059
FAX: 334.263.8631