State Employees' Health Insurance Plan
Post Screening Qualification Form

This form is only to be used to provide proof that you have addressed identified health risk(s)

Member Name (Please print)		**Male** ☐ **Female** ☐	**Employee** ☐ **Spouse** ☐ **Retiree** ☐ **Age:** _____
Contract Number	**Social Security Number**	**Date of Birth**	**Day Time Phone Number** **( )**

I have participated in a wellness screening at the worksite, county health department, or pharmacy and one or more of the following health risk(s) was identified.

- blood pressure systolic reading of 160 or higher, or diastolic reading of 100 or above
- total cholesterol reading equal to or above 250
- glucose reading equal to or above 200
- body mass index equal to or above 40

You are still eligible to earn the wellness premium discount by providing proof that you have addressed your health risk(s) in one of the following ways. The identified health risk must be addressed on or before October 31st for a January 1 premium discount.

☐ I was counseled by my healthcare provider regarding the health risk(s) identified in my wellness screening results and *I have attached one of the following*:
- A Wellness Program Office Visit Referral that has been signed by my healthcare provider, or
- A completed Provider Screening Form documenting my results.

☐ I participated in a Physician Supervised Weight Management/Nutritional program.

Name and Phone number of program: _____

Date(s) I attended: _____

☐ I participated in a SEIB Fitness Center's wellness program (i.e.: YMCA, Curves)

Name and Phone number of program: _____

Date(s) I attended: _____

Program description: _____ (i.e.: aerobics)

☐ I am self-managing my identified health risk(s). Attached is *valid proof* that I have made improvement in my identified health risk(s). **NOTE:** you must have made improvement in all identified risk(s) in order to qualify for the discount.

This information must be received in our office no later than October 31.
Incomplete forms will not be processed.

Please return completed form to:
STATE EMPLOYEES' INSURANCE BOARD
PO BOX 304900
MONTGOMERY, AL 36130-4900
1-866-838-3059 / FAX: 334-517-9980