

Health Risk Premium "Practice" Exemption Form

In preparation of the Health Risk Premium taking effect October 2013, TeamHealth employees and spouses with medical insurance through UnitedHealthcare are encouraged to take part in a "Practice Year." Because this is a practice year, the additional premium will not apply. Those who complete and submit this form by September 30, 2012, will be entered in a drawing for one of five iPads.

Form Submission Instructions

- This form is to be completed by TeamHealth medical insurance participants (employees and spouses) covered through UnitedHealthcare.
- This form is not valid unless each section is completely filled in.
- Section A should be completed by TeamHealth medical insurance participants.
- Participants have the option of having a clinician input biometric information into Section B or attaching results from a health screening to this document. If health screening results are not attached, Section B must be completed by a healthcare provider.
- If the screening takes place at a healthcare provider's office, ask the provider to complete and fax this form, or to include the completed form with the return of your screening results so you can fax the form.
- Fax the completed form to the Advanced Plan for Health (third party administrator) at 972.580.1363 by September 30, 2012, to qualify for the drawing of one of five iPads.
- Direct questions to LiveWell@TeamHealth.com or 877.516.7492.

SECTION A – To be completed by TeamHealth medical insurance participant (does not apply to children)

Participant name (please print) _____

Last four of SSN _____

Email _____

Employee Spouse

_____/_____/_____
Date of birth

Male Female

Health risk assessment and tobacco status requirements

	Yes	No
I certify that I completed the health risk assessment on myUHC.com with biometric information (body weight, blood pressure, cholesterol, etc.) between July 1, 2011, and September 30, 2012.	<input type="checkbox"/>	<input type="checkbox"/>
I certify that I (i) do not presently smoke or use tobacco products, and (ii) have not smoked or used tobacco products during the 6 months immediately preceding this form.	<input type="checkbox"/>	<input type="checkbox"/>

Privacy statement

By signing, I understand that I am disclosing my health screening results to the Advanced Plan for Health (APH), a third party administrator providing health risk analysis and other services related to health management for the TeamHealth Health Plan. All information released to APH will be protected in accordance with applicable law.

I also certify that all information is correct. I understand that falsification of information is a violation of company policy, which is subject to disciplinary action up to and including termination of employee's employment.

Participant signature _____

Date _____

SECTION B – To be completed by a clinician (if results of a health screening are not attached)

Health Measurement	Participant Value	Acceptable Value
Height and Weight (for BMI calculation)		BMI < 30
Waist Circumference (if measured by healthcare provider)		< 35 inches (women) < 40 inches (men)
Blood Pressure		< 140/90 mm Hg
LDL Cholesterol		< 160 mg/dL

Clinician name (please print) _____

Clinician signature _____

Fax completed form to the Advanced Plan for Health at 972.580.1363.

