Instructions for Receiving Your Vital Numbers Health Screening With Your Health Care Provider

We are pleased that you are participating in the Vital Numbers health screenings this year. The screening measures your BMI, blood pressure, total cholesterol, blood glucose, and tobacco-free status. ***If you are a Cummins new hire or have experienced a qualified life event***, your (and your spouse/domestic partner's, if applicable) completed Vital Numbers Data Form and registration with Virgin Pulse must take place within 90 days of your hire date to continue receiving the health plan incentive discount for the remainder of 2015.

To earn the $600 health plan incentive for 2016, you (employee) must earn **12,000** HealthMiles, and your spouse/domestic partner (if applicable) must earn **6,000** Health Miles.

- If you earn the incentive by September 30, you will see your health plan discount when you enroll for coverage in the fall during Open Enrollment.
- If you earn the incentive after September 30 but before the end of the year, your health plan discount will be effective on February 1 of the following year.

Completing the health screening is an easy way to **earn 2,000 HealthMiles**, with additional HealthMiles awarded if your screening measures fall within the healthy range.

Participation in the health screening is confidential. Please review these instructions to ensure that your information is complete and sent to the correct location.

See your Health Care Provider

1. Call your Health Care Provider to schedule an appointment for your screening.
2. Fill out the Participant Information section of the Data Form.
3. Leave the Data Form with your doctor, and instruct the doctor to fill out the Body Measurements & Biometric Results section of the form.
4. Let the clinic/doctor know that the completed form must be faxed within 90 days of your Cummins hire date (if a new hire) or by **December 31, 2015** to:

Wellness Corporate Solutions
Attn: Information Management
SECURE FAX: 877-282-3709

Screening results obtained on or after **January 1, 2015** may be used to complete the data form. **Regardless of screening date, your Health Care Provider must sign the form.**

ALL RESULTS MUST BE ENTERED INTO THE APPROPRIATE BOXES ON PAGE 2 OF THIS FORM. SEPARATE FORMS CANNOT BE REVIEWED OR PROCESSED.

If you have any questions please contact Wellness Corporate Solutions at 1-877-469-5411.

Premise Health. Keep your edge.

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DATA FORM FOR HEALTH SCREENING WITH YOUR HEALTH CARE PROVIDER

CUMMINS

PARTICIPANT: Complete participant information, bring form to provider for completion. Retain a signed copy for your records.
PROVIDER: Complete Body Measurements & Biometric Results and sign the form.
FAX completed form to Wellness Corporate Solutions at **877-282-3709** by **December 31, 2015**

I understand that the purpose of my health screening is to evaluate my health status and any potential health risks. I hereby request and authorize Premise Health, along with its subcontractors, including Wellness Corporate Solutions, LLC ("Premise Health") to transmit health information about me to the Virgin Pulse, Inc., a company that provides services to my employer, so that these companies may help me reduce, manage and/or control any such health risks. I understand that Premise Health will not provide my employer any health information that identifies me. I acknowledge and agree that Premise Health may provide my employer aggregate statistical health information which includes my health information. I understand that Premise Health may also use my health information for its own internal business purposes such as to develop future wellness programs. Finally, I understand that I may faint, bruise, or have other effects as a result of my blood being drawn. I voluntarily agree and consent to participate in the health screening and accept and assume all risks associated with such participation. I hereby release and forever discharge Premise Health, its owners, employees, and agents from any and all claims, demands, actions, and damages, including attorney's fees and costs, arising out of or in any way related to my participation in the health screening.

PARTICIPANT SIGNATURE (REQUIRED) DATE

PARTICIPANT INFORMATION (TO BE COMPLETED BY THE PARTICIPANT)

FIRST NAME

LAST NAME

DATE OF BIRTH (MM/DD/YYYY) M M / D D / Y Y Y Y

UNIQUE ID#

GENDER: ○ Male ○ Female

RELATIONSHIP: ○ Employee ○ Spouse/Dependant

PHONE NUMBER - -

HOME STREET ADDRESS

CITY

STATE

ZIP CODE

EMAIL ADDRESS

BODY MEASUREMENTS & BIOMETRIC RESULTS (TO BE COMPLETED & FAXED BY HEALTH CARE PROVIDER)

SCREENING DATE M M / D D / Y Y Y Y

FASTING STATUS: ○ Yes ○ No

BODY COMPOSITION & BLOOD PRESSURE		BLOOD TEST RESULTS	
HEIGHT (without shoes)	feet . inches	TOTAL CHOLESTEROL	mg/dL
WEIGHT (without shoes)	. Pounds	HDL CHOLESTEROL	mg/dL
BMI	. kg/m^2	LDL CHOLESTEROL	mg/dL
WAIST	. Inches	TRIGLYCERIDES	mg/dL
BLOOD PRESSURE	/ mmHg	GLUCOSE	mg/dL
NOTES:		TOBACCO USE: ○ YES ○ NO *(Have you used tobacco in the last 90 days?)*	

ALL DATA MUST BE PROVIDED ABOVE USING PRE-DEFINED FIELDS. ATTACHMENTS WILL NOT BE REVIEWED OR PROCESSED.

HEALTH CARE PROVIDER SIGNATURE (REQUIRED)

PHONE NUMBER (Provider/Clinic) - -

PLEASE FAX COMPLETED DATA FORM TO: WELLNESS CORPORATE SOLUTIONS, SECURE FAX: 877-282-3709