LIVEWELL
Be healthy. Stay healthy.

HEALTH RISK PREMIUM EXEMPTION FORM

TeamHealth employees and covered spouses or domestic partners should complete their information on separate forms. If you do not currently meet exemption, multiple forms can be submitted prior to the September 30, 2013 deadline.

Form Submission Instructions

- This form is not valid unless each section is completely filled in.
- Section A should be completed by TeamHealth health insurance participants.
- Participants have the option of attaching results from a recent screening (completed between July 1, 2012 & September 30, 2013) 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.
- Send the completed form to Advanced Plan for Health (third party administrator) by faxing it to 972.580.1363 (confidential fax number) or emailing the form to LiveWell@aph-online.com by the September 30, 2013 deadline.
- Direct questions to LiveWell@TeamHealth.com or 877.516.7492.

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

Participant name (please print) _____ Employee SSN (also needed for Spouse/DP) _____

Email _____ Employee _____ Spouse _____ Same Sex Domestic Partner (DP) ____

Date of birth _____ / _____ / _____ Employee ID No. _____ _____Female _____ Male

Health risk assessment and tobacco status requirements:

	Yes	No
I certify that I completed the health risk assessment on myUHC.com between July 1, 2012 and September 30, 2013.		
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.		

Privacy statement

By signing, I understand that I am disclosing my health screening results to 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		< 35 inches (women) < 40 inches(men)
Blood Pressure		< 140/90 mm Hg
LDL Cholesterol		< 160 mg/dL

Clinician name (please print) _____ Phone # _____
(may not be participant)

Clinician signature _____ Date of service _____

Fax completed form to Advanced Plan for Health at 972.580.1363 or LiveWell@aph-online.com.