



## Whirlpool Wellness Activity Self Report Form for Retirees

<b>Mail:</b> HealthSCOPE Benefits P. O. Box 178 Little Rock, AR 72203  Or email whirlpool@healthscopebenefits.com	<b>OR</b>	<b>Fax:</b> 877-240-0135 or 501-225-9153  Do not include a cover letter. Fax this claim form followed by your proof of activity.
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www.healthscopebenefits.com

800-660-6212

**If you need to report an activity to count towards Level 2 benefits, please complete and submit this form.**

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Retiree Last Name	Retiree First Name	Middle Initial	ID# on HSB ID Card
Address	City	State	Zip Code
Daytime Telephone Number	Email Address		

Date (MM-DD-YY)	Provider	Type of Service*	Activity Description	Who Service is For

\* Type of Service—Please insert the appropriate number for the service from the list below  
 1-Dental Cleaning 2- Routine Vision 3-Flu Shot 4-Pneumonia Vaccine  
 5-Aspirin Therapy (coordination with your physician is required)

**Certification:**

I hereby certify that the above information is correct. I further confirm and validate that:

- The service or activity is for me or my covered spouse;
- This service/activity was completed on or after my effective date;
- If I am indicating aspirin therapy as my activity, I certify that I take aspirin as part of my wellness regimen and as directed by my doctor. Or, I certify that my physician has determined that I should not take aspirin as a result of my other health conditions.

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Signature	Date
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