

## State Employees' Health Insurance Plan Provider Screening Form

**Prior Authorization (Must complete before the Screening)**

I have read the Notice Regarding Wellness Program, understand the policies and procedures set out in the Notice to protect the privacy and confidentiality of my personally identifiable health information, and agree that my personally identifiable health information contained on this Screening Form may be disclosed and/or used in the manner described in the Notice. I further acknowledge that I am participating in this Wellness Program voluntarily in order to identify whether I am at increased risk for certain medical conditions resulting from high blood pressure, obesity, high cholesterol, or diabetes.

Participant Signature

**Instructions: You are to complete Section 1 of the form and your provider is to complete Section 2. The screening must be completed no later than October 31 and submitted to SEIB by November 15.**

**NOTE: Incomplete forms will not be processed. Refunds are not allowed.**

**SECTION 1 (To Be Completed by Participant)**

<b>Name (Please print)</b>		<b>Screening Date</b>	Male <input type="checkbox"/> Female <input type="checkbox"/>	Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Retiree <input type="checkbox"/> Age: _____
<b>Insurance Number</b>	<b>Group #</b>	<b>Last 4 SSN #</b>	<b>Date of Birth (00/00/00)</b>	<b>Day Time Phone Number</b> (     )

**Do you have (or have you been told you had) any of the following? (Mark all that apply.)**

- High Cholesterol                     
  High Blood Pressure                     
  Diabetes

**Do you take Medication for any of the following? (Mark all that apply.)**

- High Cholesterol                     
  High Blood Pressure                     
  Diabetes

**SECTION 2 (To Be Completed by Provider) NOTE: The requested labs below are the only labs considered for coverage if the participant is being seen for an SEIB wellness screening only.**

\*Biometric screening could not be completed due to Pregnancy or Disability\*

<b>Blood Pressure</b> _____ / _____ <b>Total Cholesterol</b> _____ mg/dL <b>HDL Cholesterol</b> _____ mg/dL <b>LDL Cholesterol</b> _____ mg/dL <b>Triglycerides</b> _____ mg/dL <b>Blood Glucose</b> _____ mg/dL	<b>Height</b> _____ ft. _____ in <b>Weight</b> _____ <b>Waist Measurement</b> _____ <b>Waist/Ht Ratio</b> _____ <b>BMI</b> _____
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**Provider's Name: (Please print)** \_\_\_\_\_

**Provider Signature:** \_\_\_\_\_

**Provider Address:** \_\_\_\_\_

Please return completed form to:  
**STATE EMPLOYEES' INSURANCE BOARD**  
**WELLNESS DIVISION**  
 P O BOX 304900  
 MONTGOMERY AL 36130-4900  
 1.866.838.3059 / FAX: 334.517.9980

# STATE EMPLOYEES' INSURANCE BOARD

## NOTICE REGARDING WELLNESS PROGRAM

(For Use with Provider Screening Form)

The State Employees' Insurance Board (SEIB) Wellness Program is a voluntary wellness program available to all state employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

If you choose to participate in the wellness program, you will be asked to complete a biometric screening, which will include taking your blood pressure, and measuring your height, weight, and waist size. It will also include taking a blood sample to check your cholesterol (total, HDL (good), LDL (bad), and triglycerides), and glucose. You will also be asked whether you have or have had high cholesterol, high blood pressure, or diabetes and whether you take medicine for those conditions. The screening is intended to let you know whether you are at risk for certain medical conditions resulting from high blood pressure, obesity, high cholesterol, or diabetes. You are not required to participate in the wellness program and/or participate in the blood test or any other components of the biometric screening.

All active employees, covered spouses of active employees, non-Medicare retirees, and non-Medicare covered spouses of retirees, who are covered under the State Employees' Health Insurance Plan (Group 13000) and who choose to participate in the wellness program, will receive an incentive in the form of a wellness premium discount. Although you are not required to participate in the wellness program, only those in Group 13000 who qualify will receive the premium discount.

Employees who have their health insurance coverage other than in Group 13000 are eligible and encouraged to participate in the wellness program, but will not receive an incentive/premium discount.

The results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks.

### Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and the State of Alabama may use aggregate information the SEIB collects to design a program based on identified health risks in the workplace, the SEIB Wellness Program will not disclose your screening results either publicly or to your employer, except as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving a premium discount. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the SEIB Privacy Officer at 334-263-8413.