Catholic Diocese of Cleveland

ANNUAL PHYSICAL AND TOBACCO ATTESTATION FORM

INSTRUCTIONS FOR HEALTH CARE PARTICIPANTS

The Catholic Diocese of Cleveland is committed to helping you and your family achieve your best health! Part of good health is completing age and gender appropriate preventive care with a primary healthcare provider such as a family doctor. Your doctor or provider will tell you what types of preventative care may be appropriate for you.

Your health is important to us all and the Diocese will reduce the cost of your health care premium payments if you visit a physician and complete your preventive care exam between the dates of May 1, 2020 and April 30, 2021.*

NOTE: The preventative exam and the wellness tests, such as blood pressure, cholesterol levels, and fasting blood sugar levels are covered at 100%. If you are covered under the MMO PPO/HSA Plan or the MMO PPO Plan, you would need to go to a lab that has agreed to the Maximum Allowable Cost in order for the wellness tests to be covered at 100%. Other tests your physician may recommend may not be covered at 100%, such as testing for vitamin D levels and testing for thyroid abnormalities. To confirm level of coverage for optional tests, you can contact Medical Mutual of Ohio (800) 610-2583 before undergoing such tests. You can also log into your My Health Plan account at member.medmutual.com and click My Care Compare to compare costs between doctors and medical service providers.

The Diocese will also reduce the cost of your health care premium payments if you do not use nicotine/tobacco products and attest to that by April 30, 2021. You can also receive the reduced health care premium by enrolling in Medical Mutual's Quitline nicotine/tobacco cessation program by May 1, 2021.*

*Participants must be enrolled in a Diocesan Medical Plan (non-Medicare primary) in order to receive an incentive.

IMPORTANT – Both you and your covered spouse must fully complete and submit SEPARATE forms to achieve the incentive if you have family medical coverage.

What is the incentive?

- Preventative Physical Incentive:
  - Single Coverage: $15 reduction in monthly premium payments, totaling $180 annual premium reduction
  - Family Coverage: $30 reduction in monthly premium payments, totaling $360 annual premium reduction
- Tobacco Free Incentive:
  - Single Coverage: $15 reduction in monthly premium payments, totaling $180 annual premium reduction
  - Family Coverage: $30 reduction in monthly premium payments, totaling $360 annual premium reduction

If you wish to participate in the Diocesan wellness incentive program, this Physical and Tobacco Attestation Form needs to be completed by you and your primary care provider. Please review your form before submitting to ensure:

- your primary care provider completed, signed and dated the form
- you completed the Tobacco Statement
- you sign and date the form

You are responsible for the submission of the incentive form(s) to the Employee Benefits Office.

Return this form to the Diocesan Employee Benefits Office NO LATER THAN May 1, 2021.

YOU WILL NOT BE ELIGIBLE FOR THE INCENTIVE PREMIUM REDUCTION FOR THE 2021-2022 PLAN YEAR IF YOUR FORM IS NOT RECEIVED BY MAY 1, 2021 (*NO EXCEPTIONS*)

MAIL: Employee Benefits Office
1404 East Ninth Street, 8th Floor
Cleveland, OH 44114
FAX: 216-621-9622
EMAIL: hbo@dioceseofcleveland.org

If you have questions, please call 216-696-6525 x 5040

Catholic Diocese of Cleveland

ANNUAL PHYSICAL AND TOBACCO ATTESTATION FORM

Annual Physicals Must be Completed Between May 1, 2020 and April 30, 2021

Participant Name:
(*Please print clearly*): _____ Phone #: _____

Employee's SS#: _____ Employee ☐ Spouse ☐ Date of Birth: _____

Email: _____

TO BE COMPLETED BY PHYSICIAN

I hereby acknowledge that above participant completed a preventive care physical.

Physician License #: _____

Date of Physical: _____

You may record date of annual physical completed since May 1, 2020 without an additional office visit.

Provider/Physician: Once this form is complete and signed, please return it to the patient for submission.

Provider Signature: _____

Printed Name: _____

Phone Number: _____ **Date: _____**

TO BE COMPLETED BY PARTICIPANT (TOBACCO STATEMENT)

Employee ☐ Spouse ☐

Have you used tobacco/nicotine products within the past 90 days? YES ■ NO ☐

**** I am interested in enrolling in Nicotine/Tobacco Cessation: _____**

Tobacco or nicotine usage *includes, but is not limited to: cigarettes, E-cigarettes, cigars, vaping, pipe smoking, snuff, chewing tobacco, nicotine patch, nicotine gum or other nicotine supplements.*

**** Nicotine/Tobacco Cessation:** If you are interested in quitting any form of nicotine and/or tobacco use, the Diocese of Cleveland will award you with the same premium reduction incentive as participants who do not use nicotine/ tobacco when you participate in the Medical Mutual Quitline program. **You must enroll in the Cessation Program by May 1, 2021.** The program is free to eligible participants. You can enroll by calling (866) 845-7702.

Participant Signature: _____ Date: _____

Return this form to the Diocesan Health Benefits Office NO LATER THAN May 1, 2021
If you have questions, please call 216-696-6525 x5040

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Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or application containing any false, incomplete, or misleading information will be subject to criminal penalties applicable to state laws.