2025 Wellness Healthcare Provider Medical Waiver Form

Member ID
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Dear Healthcare Provider,

This participant can maintain a wellness credit for completing a health questionnaire, participating in a health screening, and attesting they have a primary care provider (PCP) and have had an annual physical with their PCP in the last 12 months as part of their company's wellness program. The health screening consists of the following: blood pressure measurement, BMI, weight, waist circumference, total cholesterol (non-fasting). The health questionnaire is available online and consists of questions related to the participant's health and lifestyle. The attestation that they have a PCP and have had an annual physical with their PCP in the last 12 months is available online.

If, due to a medical condition, it is medically inadvisable or unreasonably difficult for the participant to participate in the health questionnaire, health screening or PCP and annual physical attestation, please complete this affidavit and the participant will receive a waiver for all requirements. For example, pregnant women do not need to participate in the health screening to retain the wellness credit. Another example would be someone who was incapacitated due to a medical issue and unable to complete the health questionnaire and/or health screening during the completion timeline.

Please review this waiver carefully, attest to the appropriate information, and then sign and date the form at the bottom. The participant must also sign and date the form and return the completed form before their wellness activity window deadline date. Please ensure all fields are completed and retain a copy of this form for your records.

The information provided on this form will be kept confidential and will not be used for any purpose other than to determine if the participant is eligible for a waiver of the questionnaire, screening and/or PCP/annual physical attestation.

Completed by Participant:

Participant First Name (Print) **(Required)** _____ Last Name **(Required)** _____

Participant Date of Birth (MM/DD/YY) _____

Consent to Use Information: I, Participant, hereby authorize my provider to release any information within this form to my wellness program, Virgin Pulse, Inc. I understand that Virgin Pulse, Inc. will utilize this information solely for the purposes of administration of its wellness program and will dispose of this form in accordance with any applicable law.

Participant's Signature: _____ Date: _____

Completed by Healthcare Provider:

As the participant's treating Healthcare Provider, I hereby attest that it is medically inadvisable or unreasonably difficult due to a medical condition for the participant below to complete the following activities (please check any that apply):

☐ Complete a health questionnaire ☐ Complete a health screening ☐ PCP/Annual physical attestation

Health Care Provider Name: _____ Date: _____

Health Care Provider's Signature: _____

Submission Instructions:

Fax a copy of this form to **401.633.7546** or mail a copy to the following address:

ATTN: Member Services
Virgin Pulse
75 Fountain Street
Providence, RI 02902

If you have questions about the waiver process, please contact Virgin Pulse Member Services at boa.support@virginpulse.com or by calling 833.525.5788. Representatives available Monday through Friday from 8am to 9pm ET.