PLUMBERS & FITTERS LOCAL UNION #295 HEALTH & WELFARE FUND

c/o NATIONAL EMPLOYEE BENEFITS ADMINISTRATORS, INC.
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2025 WELLNESS INITIATIVE

Directions: Provide this form to your treating physician for completion. Beginning January 1, 2025, in order for your Annual Medical Deductible to remain at $250 (single) or $500 (family), this form must be completed in its entirety by your treating physician and returned to the Fund Office by fax or secure email (see above for fax number or email address). **Note, for those participant's with family coverage, in order for your Annual Medical Deductible to remain at the $500 (family) level beginning January 1, 2025 for your entire family, a wellness form must be completed in its entirety for <u>both</u> the participant <u>and</u> his/her spouse, if applicable.**

THIS FORM MUST BE COMPLETED EVERY YEAR AND SUBMITTED TO THE FUND OFFICE. If you have any questions/concerns, contact the Fund Office by calling 1-888-396-5899.

Participant Name: _____

Last Four of SSN: _____ Date of Birth: _____

If this completed form is for the Participant's Spouse, provide the following information:

Spouse Name: _____

Spouse's Last Four of SSN: _____ Spouse's Date of Birth: _____

To Be Completed By Physician

On _____ (**date cannot be before January 1, 2024 to qualify**),

_____ (Participant or Spouse's name), had an annual routine check-up performed in my office. Based on my opinion, I have referred him/her for appropriate diagnostic testing based on his/her age, sex and health condition (if necessary).

Physician Name: _____

Physician Address: _____

_____

Physician Signature: _____

Date: _____