Plumbers & Fitters Local Union #295
Health & Welfare Fund

c/o My Benefits Administrator, LLC
PO Box 10132 • Fleming Island, FL 32006
Phone: (386) 267-2108 • Fax: (334) 591-1050 • Email: admin@myballc.com

2027 WELLNESS INITIATIVE

Directions: Provide this form to your treating physician for completion. 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 email (see above for fax number and email address). **Note, for those participants with family coverage, in order for your Annual Medical Deductible to remain at $500 beginning January 1, 2027, a wellness form must be completed in its entirety for both the participant and his/her spouse, if applicable.**

Note, if your Annual Medical Deductible is currently $2,500 (single) or $5,000 (family), compliance with the Wellness Initiative in 2026 will lower your Annual Medical Deductible to $250 (single) or $500 (family) beginning January 1, 2027 for the calendar year. The deadline for the Fund Office to receive your completed form(s) is December 31, 2026.

If you have any questions/concerns, contact the Fund Office by calling (386) 267-2108.

Participant Name: ____

Last Four of SSN: ____________________ Date of Birth: ______________________

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

Spouse Name: ____

Spouse's Last Four of SSN: ____________________ Date of Birth: ______________________

To Be Completed By Physician

On ______________________________, ______________________________ had an annual
Date-to qualify, cannot be prior to 01/01/2026 — Name of the Participant or Spouse

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 conditions (if necessary).

Physician Name: ______________________________

Physician Address: ______________________________

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Physician Signature: ______________________________

Date: ______________________________