



2015-16

Wellness Program

May 16, 2015-May 31, 2016

It's no surprise...the **employees** are what make Chandler Unified School District such a unique and great district. So, we want you to be healthy emotionally, financially and physically. Not only will your wellness benefit you personally, but it will also help CUSD achieve two of the Journey 2020 goals outstanding Staff and Culture of Success. The well being of our employees is key to reaching these goals. ***To encourage you to reach your wellness goals, we are pleased to be able to offer a wellness incentive in the amount of \$200.00 for the 2015-16 year.***

PROGRAM DETAILS

- Must be enrolled in CUSD health plan effective January 1, 2016 or prior, AND
- Must be on active status when incentive is paid (June 23, 2016)

REQUIRED WELLNESS ACTIVITIES

- 1) One Physical Annual Exam **(Required)** (*Attach Explanation of Benefits (EOB) from www.myuhc.com.*)
- 2) UHC Online Health Assessment "Rally Survey" at www.myuhc.com **(Required)** (*No Documentation necessary*)
- 3) Pick one additional item from the list below **(Required)**:
- Diabetes Screening** (*Attach Explanation of Benefits (EOB) from www.myuhc.com.*)
 - Flu Vaccination** (*Attach Explanation of Benefits, Chandler Care Center Authorization Form, or a copy of the receipt*)
 - Attend the **Wellness Expo and One Class**—(*Attendance maintained in My Learning Plan based on sign in sheets. No additional documentation necessary.*)

Name of Class Attended

Time

- Weight Loss Program**
___ Lose to Win (*District sponsored will be documented as class on my learning plan based on sign in sheets*)
___ Non-district sponsored (*Attach a letter from weight loss coach stating you have attended all sessions or obtained goal*)
- If pregnant, sign up for **Healthy Pregnancy Program** by calling 1-800-411-7984 (*No Documentation Required*)
- If pregnant, complete **Well Pregnancy Check** (*Attach note from Doctor stating all pregnancy check-ups have been completed.*)
- Cancer Screening** as appropriate, e.g. mammogram, colonoscopy, skin cancer, prostate, etc. (*Attach an Explanation of Benefits (EOB).*)
- Donate Blood** (*Attach Post Donation Form*)
- Annual Eye Exam** (*Attach doctors note stating date of service and service performed.*)
- One (1) Annual Dental Cleaning** (*Attach doctors note stating date of service and service performed.*)

I _____ confirm I have completed the three required activities to qualify for payment of the wellness incentive.

Employee Signature

Worksite

Employee ID #

Date

RETURN TO BENEFITS DEPARTMENT BY MAY 31, 2016