



WELLNESS PROGRAM PARTICIPATION AGREEMENT

***This form is for Teammates (and eligible spouses, if applicable) who wish to attempt to qualify for a preferred contribution rate outside of the annual screening period.

ALL INFORMATION MUST BE COMPLETED! MISSING INFORMATION WILL DELAY YOUR SCREENING REQUEST.			
Teammate Information		Spouse Information	
Name:		Name:	
Teammate Number:	Hire Date:	Last 4 Digits of SSN:	
Date of Birth:	Gender (M/F):	Date of Birth:	Gender (M/F):
Phone Number:		Phone Number:	
Email:		Email:	
Home Address:			

I, _____, understand that:
(print Teammate name)

- I must be an active Teammate for 30 days before any screening can be scheduled.
- If my spouse is participating, he/she must be enrolled in the Team Fishel Health Plan and I must have completed an enrollment form indicating my intent to enroll him/her as a dependent spouse.
- I will be charged \$189* to cover the cost of my screening. If my spouse is participating, the total cost for both of us is \$378*. This cost will be deducted from my paycheck in \$50 weekly increments until the balance is paid.
- I am responsible for any cost associated with rescheduling or canceling an appointment for myself and/or my spouse.
- If I fail to show for my scheduled appointment, and/or if my spouse fails to show for a scheduled appointment, I may be charged the full cost of that appointment as well as any cost associated with rescheduling a missed appointment.

**Add 25% surcharge if located in California or Washington DC area.*

Teammate Signature: _____ Date: _____

Please return completed form to:
 Team Fishel
 Attn: Human Resources
 1366 Dublin Road
 Columbus, OH 43215
 (614) 272-0498 fax
dltanner@teamfishel.com