WELLNESS PROGRAM
ACKNOWLEDGEMENT AND DECLINATION FORM
FOR ELIGIBLE EMPLOYEES AND SPOUSES

I, (print full name) _____, hereby acknowledge and understand that I am waiving my rights to participate in the Wellness Program, which includes the following:

- Confidential Health Risk Assessment, Biometric screening and Coaching session(s). All medical information is personal and confidential, as protected by federal law. Forsyth County does **NOT** have access to your individual results.

- **For Employee-Only Coverage:**
  $30.00 per pay period deduction on my medical premium which equates to an annual savings of $720.00 if I participate and comply with the wellness program.

- **For Employee Plus One or Family Coverage (that includes a spouse):**
  $50.00 per pay period deduction ($30.00 for employee and $20.00 for spouse) on my medical premium which equates to an annual savings of $1200.00 if both my spouse and I participate and comply with the wellness program.

- Eligibility to earn a **$250** Waist/Weight Incentive if I meet the criteria and comply with the wellness program. Only employees are eligible for this additional incentive.

Full details on the program can be found on http://fcnet/HumanResources/Wellness.aspx

Please check the appropriate box(es) below to decline participation:

☐ Employee Not Participating
☐ Spouse Not Participating
☐ Employee and Spouse Not Participating

Signature _____

Employee ID Number _____

Date _____

Please return the completed form to County Human Resources by May 17, 2024
Retain a copy for your records.