WELLNESS PROGRAM
ACKNOWLEDGEMENT AND DECLINATION FORM
FOR RETIREES 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 Retiree-Only Coverage:**
  $60.00 per pay month deduction on my medical premium which equates to an annual savings of $720.00 if I participate and comply with the wellness program.

- **For Retiree Plus One or Family Coverage (that includes a spouse):**
  $100.00 per month ($60.00 for retiree and $40.00 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.

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

☐ Retiree Not Participating
☐ Spouse Not Participating
☐ Retiree and Spouse Not Participating

Signature _____

Date _____

Please return the completed form to Forsyth County Human Resources by April 25, 2019

You may make a copy for your records.