



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 11, 2020
Retain a copy for your records.***