

# 2024 Plan Year

## **Preventive Care Visit Form**

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Participation in this preventive care initiative is completely voluntary. If you, the health plan member, choose to participate, you must complete this form and return to Human Resources by **June 30, 2024**.

**Dear Health Plan Member,**

Prevention and early detection are critical components when it comes to controlling your health and managing health care costs. This year, we are encouraging employees and spouses enrolled in the medical plan to get a preventive age/gender/risk-appropriate screening from your physician. Preventive services may include but are not limited to, a general wellness exam, mammogram, colonoscopy, pap smear, etc. You as the health plan member are responsible for knowing what is covered under your medical plan and you will be responsible for any additional charges that your visit may incur. For more information on what is included as preventive, please visit UMR's website for a list of covered services. You can also contact Accolade for any additional questions you may have.

Please note that annual wellness exams reset with each calendar year. Failure to complete your wellness exam and return the completed form by the deadline will result in cancellation of the discount and you will be retroactively charged the discounted amount that was earned previously throughout the year.

Employees and spouses are both encouraged to participate. If you choose to complete a preventive visit and submit this form, you will receive a \$25 per month medical premium discount for Employee only and/or Employee + Child(ren) coverage. If you enroll with a spouse and they also complete the form, you will receive \$50 per month medical premium discount.

Please schedule a preventive visit with your physician and ask your physician to complete this form. Once completed, you must return it to Human Resources by **June 30<sup>th</sup>** to be eligible for the wellness premium discount.

Patients Name: \_\_\_\_\_

Employee Name (if different than above): \_\_\_\_\_

Health Plan Member Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Physician Instructions:**

Bridge Investment Group is encouraging employees to schedule an age/gender/risk appropriate preventive screening with their physician. **Please bill this visit as preventive** so that he/she is not charged for this visit. Thank you.

Authorized Name (Print): \_\_\_\_\_

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please submit your completed form to [benefits@bridgeig.com](mailto:benefits@bridgeig.com) or fax to 801-506-1467.