

Wellness Dollars – Request to Waive Requirements

A Member Information

Legal Name (First) ()	MI	Last	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Home Phone	Birth Date (MM/DD/YYYY)		Member ID, found on <i>myPortico</i> in the upper right corner after you sign in

B Physician Information (Please Print)

Name (First)	Last	() Office Phone
Office Address		
City	State	ZIP Code

C Information to Support Waiver Request (To Be Completed by Physician)

Portico Benefit Services offers wellness dollars as a financial incentive to encourage members and spouses with ELCA-Primary health benefits to complete wellness activities, which vary by year.

Due to illness, injury, or mental disorder, the individual named in Section A is requesting to waive participation in wellness activities for the current plan year.

Do you believe this individual’s condition makes participation in wellness activities unreasonably difficult or medically inadvisable?

No Yes

If yes, describe below how the individual’s condition prevents his or her participation in the wellness activities. Attach a separate sheet of paper if you need more space. Please print.

D Signature of Attending Physician

I hereby affirm the information provided is complete and true to the best of my knowledge. I understand that this waiver request only applies to the current plan year, and a new request must be submitted each year.

Signature of Physician (Required)	Date (MM/DD/YYYY)
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Mail or fax this completed form by November 30 to the Portico Customer Care Center.

Portico Benefit Services	P 800.352.2876	mail@PorticoBenefits.org
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Minneapolis, MN 55402-2892	F 612.334.5399	