

REASONABLE ALTERNATIVE STANDARD FORM - NELNET

The Nelnet wellness program allows associates, spouses, and domestic partners to earn a wellness reward for achieving the health goals below, based on health screening results. Screenings can be completed onsite, with a physician screening form, or with a laboratory voucher. If you do not meet the goals outlined below, your physician can complete the bottom portion of this form to waive goals. You are responsible to scan and upload your completed form to <https://nelnet.uswellness.com> on or before **9/30/2023**. Receipt of your form will be confirmed within two business days to the email provided below (please print clearly and allow emails from uswellness.com). **This form should only be used for goal waivers; results submitted on this form will not be accepted.** NOTE: To obtain the full reward, you must either meet each goal or obtain a waiver from your physician for any goals you do not meet.

STEP 1: To be completed by associate or spouse/domestic partner

I am an Associate I am the Spouse/DP of a Nelnet employee Associate Clock ID Number: *If you are a spouse or domestic partner, please list "S" after your clock ID number.

First Name Last Name

Date of Birth: Gender: Female Male

E-mail address (to receive e-mail verification that form was received by US Wellness)

STEP 2: To be completed by associate or spouse/domestic partner AND provider

CERTIFICATION OF TOBACCO USE: Tobacco use includes habitual use of chewing tobacco, cigarettes, cigars, pipes, E-cigarettes or E-cigars (electronic cigarettes and cigars) within the past 90 days. Please mark the appropriate box. By signing below, you agree that the information provided is accurate and true. **Falsifying this information can lead to disciplinary action.**

Yes, I have used tobacco products in the past 90 days
 No, I have not used tobacco products in the past 90 days

Please have your health care provider initial here to verify tobacco status. X

STEP 3: To be completed by employee or spouse/domestic partner

I understand that any individually identifiable health information about me obtained in the course of this screening may be maintained by US Wellness. I authorize US Wellness to share my individually identifiable health information with organizations affiliated with my company's wellness program under Business Associate Agreement for the purpose of providing wellness services. I understand that my information will not be shared with my employer. I authorize that US Wellness or its affiliates may contact me and that my information will be managed in accordance with the uses and disclosures permitted of covered entities under the federal HIPAA Privacy Rule. I may revoke this authorization through written communication to privacy@uswellness.com. Revocation of this consent will apply to data sharing that has not yet occurred at the time of the revocation. By signing below, I acknowledge that I have read, understand, and accept all of the statements on this consent form.

X _____
 Employee/Spouse/Domestic Partner Signature (SIGNATURE REQUIRED) Date

STEP 4: To be completed by physician office ONLY

Physician Waiver: The Nelnet wellness program allows associates, spouses and domestic partners to earn a wellness reward for achieving certain health goals. The purpose of the program is to promote health and prevent disease. Your patient is requesting you to discuss with them appropriate health goals based on their circumstances. Your patient is also requesting you to waive them from having to meet one or more goals based on their circumstances and your medical judgment. **Please indicate which goals should be waived below; screening results should not be reported on this form:**

Employer-Defined Wellness Goal		Waiver Selection
Tobacco Use	Patient must be tobacco free or have waiver by 9/30/2023 for full reward; discounts also available for enrollment in ComPsych or Wellnet's tobacco cessation program by 9/30/2023 .	<input type="checkbox"/> Goal waived by physician
Total Cholesterol -OR- Total Cholesterol/HDL ratio	≤200 mg/dL <input style="width: 100px; background-color: black; color: black;" type="text"/> -OR- ≤ 5.0 <input style="width: 100px; background-color: black; color: black;" type="text"/>	<input type="checkbox"/> Goal waived by physician
Body Mass Index -OR- Waist Circumference -OR- Body Fat %	≤25 BMI <input style="width: 100px; background-color: black; color: black;" type="text"/> -OR- ≤38 inches men; ≤33 inches women <input style="width: 100px; background-color: black; color: black;" type="text"/> -OR- Ages 20-39: Women ≤33%; Men: ≤20%, Ages 40+: Women ≤34%; Men: ≤21%	<input type="checkbox"/> Goal waived by physician
Blood Pressure	≤120/80mmhg <input style="width: 100px; background-color: black; color: black;" type="text"/>	<input type="checkbox"/> Goal waived by physician
Fasting Blood Glucose	≤100mg/dL <input style="width: 100px; background-color: black; color: black;" type="text"/>	<input type="checkbox"/> Goal waived by physician

Physician Name Physician Signature Date Phone Number

STEP 5: To be completed by employee or spouse/domestic partner

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