State of SD Employee Health Plan FY25 Biometric Screening Form

1. Complete all participant information, including email address, and sign the form.
2. Visit your primary care provider for your annual wellness exam between 4/2/2024 and 4/1/2025. Ask your provider to complete the Biometric Screening information section and sign the form.
3. Review results with your provider.
4. Forms must be RECEIVED by 4/1/2025. Submit your form only once by uploading at https://www.totalwellnesshealth.com/gravity-landing/sdpf/ (preferred method) or fax to 402-939-0931. Forms received after the deadline will not be accepted.
5. Within 48 hours of form submission, a confirmation email will be sent to the email address you provided. If a confirmation email is not received within 48 hours, please resubmit your form. **Forms submitted between 4/2/2024 – 6/30/2024 will be processed and confirmation notifications sent on 7/1/24.**
6. Please allow 10 business days for your information to be available in your LiveWellSD account.
7. Preventive care like the annual wellness exam with blood work is covered under the health plan. However, during the annual wellness exam, if a separate diagnosis or concern is identified, and additional testing is required, those tests will be paid at the normal plan benefits, subject to deductibles and/or copays.

PARTICIPANT INFORMATION (To be completed by Participant)

Participant First Name:

Participant Last Name:

Participant Date of Birth: (mm/dd/yyyy)

/ /

Email: (Required to confirm receipt and approval. It is the member's responsibility to ensure the form has been received and approved.)

Gender: O Male O Female O Prefer not to answer

Have you fasted for at least 9 hours? (*No food. Only water permitted.*) O Yes O No

Participant Printed Name:	**Date:**
Participant Signature (required):	

BIOMETRIC SCREENING INFORMATION (To be completed by Provider)

Date of Screening: (mm/dd/yyyy) / /
(Screening Range: (4/1/2024-4/1/2025)

Blood Pressure: /
Systolic **Diastolic**

Height: **Ft.** **Inches**

Weight: **Lbs.**

Waist: **Inches**

Glucose:

Total Cholesterol:

HDL:

LDL:

Triglycerides:

PROVIDER SIGNATURE

Provider Name:	**Provider Phone Number:**
Provider Signature (required):	

Disclosure of Information. I understand that the information submitted on this form (my "Personal Information") will be transferred to WebMD by TotalWellness. My Personal Information is used by WebMD to provide wellness program services to me, which includes using the Personal Information to inform me of relevant health related and health education programs offered by WebMD or by another service contractor. In the event that WebMD's services are transitioned to another service provider, WebMD may deliver my Personal Information to the successor provider to maintain a continuity of services for me. In order to distribute any incentives, WebMD may provide my name/unique ID to my employer or its designated representative to notify them of the fact that I am eligible for the incentive. In addition to any Personal Information disclosed as set forth above, aggregate, de-identified survey results may be made available to my employer for program administration purposes. WebMD may also use my Personal Information as part of group statistical research and analysis, in a manner that does not identify me. I also understand that my Personal Information may be incorporated into my Health Assessment results by WebMD. Except for these types of usage and the uses specified in my WebMD Online terms of use and Privacy Policy, available under the "Policies" link at the bottom of the page at the following https://bhr.sd.gov/livewellsd my Personal Information will not be disclosed by WebMD. WebMD understands that Personal Information may be considered protected health information that is subject to the privacy and security rules of the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"). WebMD will comply with the HIPAA to the extent applicable.

GINA Notice and Authorization. This screening is part of your employer's wellness program ("Employer Program"), which is a voluntary wellness program administered according to federal rules, including the Genetic Information Nondiscrimination Act ("GINA"). The results of this screening may be considered information protected under GINA ("GINA Protected Information"). GINA requires that you receive this GINA Notice and Authorization prior to undergoing the screening. Your Employer Program uses GINA Protected Information to help you understand your potential health risks and to offer you other wellness program services. The Employer Program safeguards GINA protected information and will not disclose any GINA Protected Information, except as permitted by GINA and other applicable law. Your GINA Protected Information will be disclosed to you and to vendors of the Employer Program, for purposes of providing you with Employer Program services. Your GINA Protected Information will not be sold, exchanged, or transferred, except to the extent permitted by law to carry out activities related to the Employer Program. You will not be asked to waive the confidentiality of this information as a condition of participating in the Employer Program or as a condition of receiving any incentive. Your GINA Protected Information will only be disclosed to your employer in aggregate terms that do not disclose your specific identity.