



**WELLNESS PROGRAM
ACKNOWLEDGEMENT AND DECLINATION FORM
FOR ELIGIBLE RETIREES 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:**
\$60.00 per month 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 month deduction (\$60.00 for employee and \$40.00 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.

Please check the appropriate box(es) below to decline participation:

- Retiree Not Participating
- Spouse Not Participating
- Retiree and Spouse Not Participating

Signature _____

Last four of SSN _____

Date _____

Please return the completed form to County Human Resources by **July 7, 2016**
You may mail it to Human Resources at 201 N Chestnut Street, WS, NC 27101
or fax it to 336-727-2193

You may make a copy for your records