BIO25 – Biometric Screenings Form FOR 2025 OPEN ENROLLMENT ONLY

BIO25 – PROVIDER DATA ENTRY FORM

GENERAL INFORMATION

PLEASE PRINT CLEARLY AND STAY WITHIN THE BOXES BELOW

PARTICIPANT (PERSON BEING MEASURED) INFORMATION – Completion required.

First Name:

Must match the name on record for your health benefits.

Last Name:

DOB (MM/DD/YYYY):

Member ID# U

Spouses/Domestic Partners have a distinct Member ID# that is separate from the Subscriber's Member ID#. Enter the Member ID# of the person being measured.
If you do not know your Member ID#, you must complete the field for SSN below.

SSN: - -

If you have entered your Member ID# above, you may leave the field for SSN blank.

Important: This form is ONLY for current UEBT/UCBT Members and Spouses/Domestic Partners who are completing their Wellness Steps for 2025 benefits.

If you are the Spouse of a Member, you must submit your completed GINA Agreement to the Trust Fund Office before completing and submitting this form

By submitting this form, I am authorizing my physician to report the laboratory and biometric results to UFCW & Employers Trust, LLC for my Biometric Health Screenings, and for UEBT/UCBT to collect such information. If I am a Participant in the UEBT/UCBT Plan because I am the Spouse of a Member, I further acknowledge that by agreeing to this authorization, I am providing information regarding my current or past health status (or manifestation of disease or disorder) and that I authorize the use of this information for the purposes described in the Biometric Screenings Instructions.

1. *Please review the Biometric Screenings Instructions to verify you need biometric screenings tests prior to having any done.*
2. *You, the Participant, are responsible for meeting all program deadlines. You, the Participant, must collect this form from your physician or clinician and submit to UFCW & Employers Trust, LLC, as prescribed. Only one physician form can be submitted per person.*
3. *See the program description in your enrollment materials for more details. Please keep a copy of this physician complete form for your records.*

Participant's Signature: _____ Date (MM/DD/YYYY):

Please upload this form to your Participant Account on ufcwtrust.com, or fax this form to 925-746-7549

For more information, call the UFCW Trust Fund Office Health and Welfare Services Department at 800-552-2400

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GENERAL INFORMATION

Participant Last Name:

DOB (MM/DD/YYYY)**:**

FOR PROVIDER OR OFFICE STAFF USE ONLY BELOW THIS LINE

Blood Pressure

Systolic

Diastolic

Test Date (MM/DD/YYYY):

Cholesterol

HDL: TRI:

LDL: Total:

Total/HDL Ratio: .

Test Date (MM/DD/YYYY):

Glucose

Fasting Glucose:

-OR-

A1c (Fasting or Non-fasting): .

Test Date (MM/DD/YYYY):

BODY MEASURE

Height: (in.) Weight: (lbs.)

Test Date (MM/DD/YYYY):

NICOTINE USER?

☐ Y ☐ N

NOTE: Facility and agent name must be printed in the boxes.

☐ I certify these values are correct.

Facility Name:

Certifying Agent First Name:

Last Name:

NPI#:

Today's Date: (MM/DD/YYYY)

Signature: _____

NOTE: Use this area for office or facility stamp

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