Cigna Healthcare® Wellness Experience

Reasonable Alternative and Waiver Form

You may be able to earn rewards in different ways for the Cigna Healthcare Wellness Experience by asking your doctor (or Licensed Healthcare Provider) to complete and sign the form if you think you might be unable to meet a standard for a reward under the wellness experience. Please note this form applies only to the program year in which it is submitted and will need to be submitted each program year to be applicable.

PART 1: **MEMBER INFORMATION** (Participant completes Part 1)	
First Name:	Last Name:
Company or Employer Name:	Date of Birth (mm/dd/yyyy):
Preferred Phone Number:	Email:

By submitting, I verify that the information my representative or I have supplied is true and complete, and there has been no attempt made to knowingly provide any false, incomplete, or misleading information. By signing this form, you authorize the physician to release this information to Cigna.

Member Signature ____________________ Signature Date ____________________

To be completed by a Licensed Medical Provider: By checking the applicable box, the licensed medical professional is stating that the member: (1) cannot participate in the following activities due to a disability that is protected under the Americans with Disabilities Act or (2) is waived from an activity that meets the standard criteria for preventive care recommended by nationally recognized guidelines (please check all that apply):

PART 2: REASONABLE ALTERNATIVES FOR BIOMETRIC OUTCOMES (Provider completes Part 2)	
ACTIVITY BEING WAIVED	**Event Code**
☐ Achieve Healthy Blood Pressure	BPX
☐ Achieve Healthy BMI	BMX
☐ Achieve Healthy Waist	WCX
☐ Achieve Healthy Cholesterol	CTX
☐ Achieve Healthy HDL Cholesterol	CHX
☐ Achieve Healthy Glucose	FGX
☐ Other (Please specify activity):	
☐ Waived from All Activities	

Healthcare Provider Name (please print) ____________________ Healthcare Provider Signature ____________________

Title ____________________ City/State ____________________

Healthcare Provider Phone Number ____________________ Healthcare Provider Signature Date ____________________

Date of Provider's signature will be the date used to process the waiver in the system.

To submit your completed form, use the Upload function:

Upload the form electronically at cignapersonifyhealth.zendesk.com

Secure Fax: 800-526-6893

Mail: Personify Health ATTN: Member Services, 75 Fountain Street, Suite 400, Providence, RI 02903, USA

Incomplete or altered submissions of this form may delay approval.