Employer-Sponsored Wellness Program Participation Notice & Consent Form

As a part of the wellness program sponsored by your employer/your spouse's employer, you are offered an incentive to complete a *voluntary* health risk assessment (HRA)/BCBSMT Blue Value℠ Total Health Management Assessment Form through which you will provide information about your health history, health status or both. Your employer/spouse's employer may provide financial or other incentives to participate in the HRA wellness program.

Your participation in the HRA wellness program is voluntary. You are not required to participate in the HRA wellness program. If you decide to participate, and if there are questions in the HRA related to your own family medical history or your own genetic information (these questions, if any, are identified on the HRA), you are not required to answer them in order for the employee to receive any incentive we offer for completion of the HRA.

We'll use the health information you provide to help you. Findings gathered from the HRA will be used to provide you with information to help you understand your current health and potential risks and may also be used to offer health-related services to you.

Your health information is confidential. We are required by law to maintain the privacy and security of your personally identifiable health information. The medical information collected will not be available to your employer/your spouse's employer in a way that allows your employer/your spouse's employer to identify spouse or employee health information. However, we may use aggregate or summary (e.g., de-identified) information from the HRA to design or provide additional health services. Any individually identifiable medical information we obtain through the wellness program will be maintained separate from personnel records, information stored electronically will be secure and confidential, and no information you provide will be used in making employment decisions.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program (including the health plan which it is a part of), and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or our provision of an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program is required to abide by the same confidentiality requirements. We may disclose your information as necessary to respond to a request from you for a reasonable accommodation to allow you to participate in the wellness program, or as expressly permitted by law.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact your employer/your spouse's employer.

I acknowledge the above and agree to participate in the wellness program health risk assessment/BCBSMT Blue Value℠ Total Health Management Assessment Form.

Please select: Employee_____ OR Employee Spouse_____

Last Name _____ First Name _____ MI _____

Email Address_____

Health Plan ID (On ID Card) _____ Group Number (On ID Card) _____

Employer Name _____ Date of Birth (mm/dd/yyyy) _____

Signature _____ Date _____

*All fields are required