PROOF OF PHYSICAL FORM

This form must be completed and signed by the participant and his or her physician, and received and accepted by the Fund Office by November 15 of each year for it to be processed in time for the participant to have Wellness Tier coverage on the following January 1.

Dear Doctor or Health Care Provider,

The I.B.E.W Local No. 38 Health and Welfare Fund has introduced a new coverage tier designed to encourage participants to get annual physical exams. I am voluntarily participating in this program. I have to provide verification that I executed an annual physical examination with my primary care provider. Please send the completed form to the I.B.E.W Local No. 38 Health and Welfare Fund as indicated below.

SECTION 1. TO BE COMPLETED BY THE PARTICIPANT
By signing this form, you agree to voluntarily authorize your physician to verify your physical examination in order to qualify for Wellness Tier coverage.

DATE: _____

PARTICIPANT'S NAME: _____

PARTICIPANT'S SIGNATURE: _____

SECTION 2. TO BE COMPLETED BY THE EXAMINING PHYSICIAN
By signing this form you acknowledge that you completed an annual physical examination of the Fund participant.

DATE OF THE PHYSICAL EXAM: _____

EXAMINING PHYSICIAN'S NAME: _____

EXAMINING PHYSICIAN'S OFFICE ADDRESS: _____

_____

EXAMINING PHYSICIAN'S OFFICE PHONE NUMBER: _____

EXAMINING PHYSICIAN'S SIGNATURE: _____

DATE: _____

RETURN THIS COMPLETED FORM BY MAIL, FAX OR EMAIL TO:
I.B.E.W Local No. 38 Fringe Benefits
P.O. Box 6326
Cleveland, OH 44101-1326
Fax: 216-431-7719
Email: Rachel@ibew38-benefits.com