

Premium Reward Review Form

If you have not received your premium reward for the period January 1 through June 30, 2014 and believe that you have performed all necessary actions, complete this form in full and submit to ohb@dhrm.virginia.gov or fax to (804) 371-0231 by 5:00 pm on Friday, January 31, 2014.

Employee Name: _____

Participating Spouse name (if applicable): _____

Health Plan ID # (from health insurance card): _____

Email: _____

Daytime phone #: _____

Alternate phone #: _____

Complete items 1 and 2:

1. Date & location of the onsite biometric screening :

OR

Date & location of the LabCorp biometric screening:

OR

Date Physician Screening Form sent to Well Advantage: _____

2. Date the health assessment completed: _____

(**Note:** If the assessment was completed **and** you received the reward for the July 1 – December 31, 2013 period, indicate “For 7/1/2013 Period”)

Attach important documentation. (i.e. Confirmation from Well Advantage for physician screening forms, LabCorp report, and/or certification of completion of health assessment from MyActiveHealth.com/COVA portal.)

Indicate any pertinent information.

Employee Signature _____

Date: _____