

SCREENING REGISTRATION FORM

On **February 18, 2011**, subscribers of the State Health Plan (Standard and Savings Plans), BlueChoice, and Cigna will have the opportunity to receive a thorough preventive health screening right here at our workplace. This screening, a \$350 value in many healthcare settings, will be available for just a \$15 co-payment. Your insurance pays the rest!

Within three weeks after your screening, you will receive your personal health profile, highlighting any values outside the normal range. You can even send this report to your physician or take a copy with you on your next doctor's office visit, which may save you money and keep you from duplicating tests. A detailed description of the screening components can be found online at http://www.eip.sc.gov/publications/Guide_complete.pdf

To register for this important benefit, please return this completed form to **Leslie Williams** along with a **\$15 check or money order payable to Carolina Occupational Health Screening Group**.

Terms and Conditions

- There is a 12-hour fast prior to your screening (you may have water and any required medications you may be taking)
- Participants are required to complete all components of this health screening. This includes height, weight, blood pressure, blood draw, and paperwork.
- **Please bring your insurance card with you the day of the screening.** Your insurance card ID number will be required when filling out paperwork.
- Insurance allows for **ONE** Prevention Partners screening per calendar year (January-December)
- Spouses covered by eligible employees and retirees can participate for a \$15 co-payment
- Dependent children are not eligible
- If Medicare is your primary insurance, you are not eligible

Name _____ Date of Birth _____

Home Address _____ City _____ State _____ Zip _____

Work Phone _____ Home/Cell Phone _____

Email _____

Employees and retirees (and their covered spouses) whose primary insurance through the state is one of the following are eligible to participate in the screening for a \$15 co-payment. Please check the box that represents your insurance coverage:

My primary insurance is: State Health Plan BlueChoice Cigna

I am an (check one): employee retiree covered spouse

I hereby certify that I am an employee, retiree, or covered spouse with insurance coverage through the state of South Carolina and that I have read the terms and conditions listed above. I affirm that the information I have given is true and correct. Any discrepancy may result in further billing by the provider.

SIGNATURE _____

Insurance Card I.D. Number (not your SSN#): _____