Program Alternative Waiver Application

If a member does not fall within the healthy range for a health metric and the completion of the Alternative Action is not recommended, a licensed medical professional may waive the Alternative Action in order for the member to receive credit for that health metric category.

Instructions for Waiver

- The Member Information section of the Program Alternative Waiver should be filled out by the member.
- The remainder of the form must be completed and signed by a licensed medical professional.
- Upon completion, the member or the licensed medical professional will submit the waiver by mail, fax, or internet upload (upload by member only):

SimplyWell
Attn: Screening Services Department
10670 N. Central Expwy., Suite 250
Dallas, TX 75231

Secure Fax: (855) 292-8662
Phone: (888) 848-3723
Upload to: connect.simplywell.com

Waiver Deadline

SimplyWell® must receive the completed waiver by: 8.02.2019

SimplyWell will evaluate the waiver to verify that all necessary information is complete. Approval or denial of the waiver will only apply to the applicable plan year. This process must be completed for each new wellness program year including resubmission of the Program Alternative Waiver form.
# Program Alternative Waiver

## Member Information (Please Print)

<table>
<thead>
<tr>
<th>First Name</th>
<th>Middle Initial</th>
<th>Last Name</th>
<th>Gender (Male/Female)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date of Birth (mm/dd/yyyy)</th>
<th>Email Address</th>
<th>Employer</th>
</tr>
</thead>
</table>

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.

## TO BE COMPLETED BY A LICENSED MEDICAL PROFESSIONAL:

By checking the applicable box, the licensed medical professional is recommending that the member not complete the Reasonable Alternative.

<table>
<thead>
<tr>
<th>WAIVED CATEGORY</th>
<th>ALTERNATIVE ACTION</th>
<th>SIMPLYWELL USE ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ BMI/Waist Circumference</td>
<td>Combination of online educational articles and videos specific to BMI / waist circumference and/or Health Coaching</td>
<td>□ Approved □ Denied</td>
</tr>
<tr>
<td>□ Total Cholesterol</td>
<td>Combination of online educational articles and videos specific to total cholesterol and/or Health Coaching</td>
<td>□ Approved □ Denied</td>
</tr>
<tr>
<td>□ Blood Pressure</td>
<td>Combination of online educational articles and videos specific to blood pressure and/or Health Coaching</td>
<td>□ Approved □ Denied</td>
</tr>
<tr>
<td>□ Glucose</td>
<td>Combination of online educational articles and videos specific to glucose and/or Health Coaching</td>
<td>□ Approved □ Denied</td>
</tr>
<tr>
<td>□ Tobacco Use (if applicable to member's health management program)</td>
<td>Combination of online educational articles and videos specific to tobacco cessation and/or Health Coaching</td>
<td>□ Approved □ Denied</td>
</tr>
</tbody>
</table>

Licensed Medical Professional Name (print): __________________________

Licensed Medical Professional Signature: __________________________

License Type/Number: __________________________

City/State: __________________________

Phone Number: __________________________

Today's Date: __________________________

Note: Forms submitted without the signature of a licensed medical professional will not be approved.

## Appeal Review - SimplyWell Use Only:

<table>
<thead>
<tr>
<th>□ Chief Clinical Officer</th>
<th>□ Chief Medical Officer</th>
</tr>
</thead>
</table>

Signature: __________________________

Date: __________________________

Notes: __________________________