Roofers Local No. 20 Health and Welfare Fund and Pension Trust Fund

6321 Blue Ridge Blvd., Suite 101
Raytown, Missouri 64133
816-313-9427
Fax 816-313-0004

GINA AUTHORIZATION FORM

*(Authorization to be completed by **SPOUSE** prior to the collection, in exchange for an incentive, of information regarding the spouse's health history or current health status.)*

Roofers Local No. 20 Health and Welfare Fund offers a wellness program to certain of our employees and their dependents. As part of the wellness program, spouses are invited to complete a *voluntary* Physical examination through which the spouse will provide information about his or her health history, health status or both. We may provide financial or other incentives to employees whose spouses participate in the physical examination.

We'll use the health information you provide to help you. Findings gathered from the physical examination 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 us in a way that allows us to identify you or the employee. However, we may use aggregate or summary (e.g., de-identified) information from the physical examination 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 encrypted, and no information you provide will be used in making employment decisions. Appropriate precautions will be taken to avoid a data breach, and in the event a data breach occurs, involving information you provide in connection with the wellness program, we will notify you promptly after learning of the breach.

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. In addition to you, the only individuals who will receive your personally identifiable health information will be licensed health care professions and board certified genetic counselors in order to provide you with health or genetic services under the wellness program. 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 Michelle Ross at 816-313-9427.

____ ACCEPT: I wish to participate in the voluntary physical examination

____ DECLINE: I do not wish to participate in the physical examination, and understand that by not participating neither I nor my spouse (the employee) will receive the incentive offered in exchange for my participation.

Name: _____

Signature: _____ Date: _____

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Annual Physical Examination Incentive Verification

There is no co-pay to be collected/required for a screening that is 100% preventive

This is to verify, that I, _____(Name) have

completed my Annual Physical Examination on _____(date).

Covered Adult Name:	Covered Adult Signature:	Date:
Physician Name:	Physician Signature:	Date:

Please print the following information:	
Member	
Work Phone	
Email Address	

Please keep a copy of this certificate for your records and provide the original to the Fund Administrator, Michelle Ross, by no later than **November 15, 2019**.

If you have any questions, please contact Michelle Ross at (816) 313-9427 or fax (816) 313-0004 or 6321 Blue Ridge Blvd., Suite 101, Raytown, MO 64133.

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Covered Adult Name:	Covered Adult Signature:	Date:
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