Cleveland Clinic

EMPLOYEE HEALTH PLAN
WELLNESS PROGRAM APPLICATION

WEIGHT MANAGEMENT PROGRAM

Member Name: _____ Medical ID Card No: Aetna/UMR_____

Employee Name: _____ Employee ID Number_____
(must include if dependent is joining)

Address: _____City:_____State:_____Zip: _____

Home Phone: (_____)_____ Work Phone: (_____)_____ Ext: _____

1. Cleveland Clinic Weight Management Program: _____

   Location/Address: _____

2. *Current Program Start Date: _____/_____/_____*

3. For verification of meeting attendance and future cost sharing by Cleveland Clinic, please note that you MUST return this application within 10 days of your start date. Failure to complete this application will result in non-payment of the program and financial responsibility will become the member's.

***MAIL or FAX COMPLETED FORM TO**:*
Cleveland Clinic
Employee Health Plan
25900 Science Park Drive, AC242
Phone: 216-986.1050 Toll-free: 888.246.6648
Fax: 216-448-2055

AUTHORIZATION FOR RELEASE OF INFORMATION

I am in agreement to provide my height, monthly weigh-in status, and meeting attendance records as required. *I understand this information is necessary for payment of the program. This information is completely confidential and will ONLY be used to report program success in the aggregate. I understand that payment of program fees by Cleveland Clinic will terminate upon termination of employment, if I cease to be a member of the EHP, or if I do not meet program requirements.*

Employee/Participant signature:_____ *Date*:_____

NOTE: Incomplete forms will be returned for completion and payment for program will not be made unless the form is returned.