

Annual Preventive Physical Form

Please read the below information and complete the applicable sections. This form applies only to regular full-time employees, regular part-time employees, spouses and/or qualified domestic partners. You and/or your eligible family member do not have to be enrolled in Marathon's Health Plan in order to take advantage of this program.

EMPLOYEES: Earn a \$250 payroll stipend by completing an annual preventive physical with a primary care provider. The Annual Preventive Physical Form must be used to confirm completion of an annual preventive physical. The completed form, signed by a primary care provider, must be received by HealthFitness on or before December 31, 2018, to earn \$250.

SPOUSES / QUALIFIED DOMESTIC PARTNERS: Earn a \$150 payroll stipend by completing an annual preventive physical with a primary care provider. The Annual Preventive Physical Form must be used to confirm completion of an annual preventive physical. The completed form, signed by a primary care provider, must be received by HealthFitness on or before December 31, 2018, to earn \$150.

- When completing the form, include your unique ID by combining your spouse's MPC employee ID + your birth month and date (enter 0115 for January 15) + gender (enter M or F).
 - For example if your spouses' MPC employee ID is 12345678, your birth day and month is May 4 and you are male, your UNIQUE ID would be 123456780504M

STEPS TO RECEIVE YOUR WELLNESS INCENTIVE

- 1) Register on the HealthFitness website at <http://mympcwellallways.com>
- 2) Schedule an annual preventive physical with your primary care provider. Make sure services are coded as "preventive" — remind the doctor/nurse/receptionist that you have come for a preventive exam and that services should be coded as "preventive" and not "diagnostic." Generally, in-network preventive services should be covered by your health plan at 100%. Services coded as diagnostic or coded improperly may not be covered in full and you may be required to pay a deductible and coinsurance.
- 3) Bring the Annual Preventive Physical form to the appointment and have the primary care provider complete and sign. Only an authorized signature from your primary care provider verifying the completion of the preventive physical is required to be eligible for the wellness incentive. *Biometric data is not required. If you choose to include your biometric data on the form, your data will be added to your HealthFitness account and a personalized health report will be generated for you. This data will not be provided to your employer and will not be accessible to your employer, other than in the form of an aggregate summary report generated for your employer to help in understanding the overall health of the group.*
- 4) Upon completion of an annual preventive physical, the signed form needs to be submitted to HealthFitness. Both the employee and spouse/qualified domestic partner will need to submit individual forms. In order for the eligible family members to earn the wellness incentive, the employee must complete their annual preventive physical and submit the completed form between January 1, 2018 and December 31, 2018.

Return the completed and signed form to HealthFitness Corporation through one of the following options:

- Scan and upload on the Well ALL Ways website (<http://mympcwellallways.com>) under the Screening Section.
- Fax the form to 1-866-698-9924.
- Mail in the form to the following address:
Health Fitness Corporation, 18325 Waterview Parkway, Bldg. B, Suite 200, Dallas, TX 75252

Note: Keep a fax confirmation (or have your provider keep the fax confirmation) or proof of mailing.

- 5) After HealthFitness receives your Annual Preventive Physical Form, your information will be added to your HealthFitness account and the incentive will be credited. The incentive will be applied to the employee's paycheck within 2-3 pay periods following the date on which the form was submitted. Marathon Petroleum cannot access your individual personal health information; the only information shared with MPC is if you have completed your annual preventive physical.

QUESTIONS: For any questions about this program, please contact Well ALL Ways at 1-866-808-5706.



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FAX completed form to: HealthFitness Corporation at 1-800-941-9003 or
MAIL to: 18325 Waterview Parkway, Suite B200, Dallas, TX 75252



Please remember to keep a fax or mail confirmation for your records. Call HealthFitness Customer Service at 1-888-221-0229 if you have questions.

| PARTICIPANT INFORMATION (required): Employee / Spouse / Qualified Domestic Partner must complete in information in blue boxes below | | | |
|---|--|-------------------------------------|---|
| Unique ID: (8-digit MPC employee number) (13-digit MPC spouse number) | | Full Name: (please print) | |
| Date of Birth: | | Gender: | <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Preferred Telephone Number: | | Email Address: | |

I hereby authorize the health care provider listed below to verify that I have completed a preventive physical exam on the date listed below. I further understand that providing false or misleading information on this form is subject to disciplinary action, up to and including termination of employment.

Participant Signature: _____ **Date:** _____

**BY SUBMITTING THIS FORM TO HEALTHFITNESS (WHETHER OR NOT SIGNED BY YOU),
YOU HEREBY CONSENT TO THE USE AND DISCLOSURE OF YOUR HEALTH INFORMATION AS DESCRIBED BELOW.**

Use and Disclosure of Your Information:

HealthFitness treats personally identifiable health information as confidential. The information you provide to us on this form will be used to:

- Generate a personalized health report for you, if biometric data is provided.
- Generate a summary report so your employer can understand the overall health strengths and concerns of the group. Your individual responses cannot be identified in the summary report.
- Inform you about materials, programs and services that might be useful to you.

The information you provide may be disclosed to the following individuals or groups as appropriate (as determined at HealthFitness' sole discretion):

- Authorized HealthFitness employees;
- Authorized individuals working for your employer or other third parties to the extent reasonably necessary for us to operate employer-sponsored programs in which you participate, provided the receiving party agrees to maintain the confidentiality of your information and information is used only for the purposes noted (however, no biometric data will be shared with your employer);
- Assigned contractors, their agents and successors whom we use to support our business in connection with any program sponsored by your employer in which you participate, provided the receiving party agrees to maintain the confidentiality of your information and information is used only for the purposes noted;
- Vendors, contractors and other third parties authorized to provide services and/or programs for your employer's health management plan, provided the receiving party agrees to maintain the confidentiality of your information and information is used only for the purposes noted;
- Those involved with the sale, assignment or transfer of business to which the information you give is related, provided they sign appropriate confidentiality agreements that maintain the confidentiality of your information; or
- Those with whom we are required to share your information by applicable law, court orders or government regulations.

Please note there are TWO separate sections below. Section 1 is optional, while Section 2 is required to be eligible for wellness incentive.

Section 1: BIOMETRIC DATA VALIDATION (OPTIONAL) — If biometric testing was performed, you have the option to complete the biometric data section and have HealthFitness add it to your account. This section is NOT required and does not need to be completed to earn the wellness incentive.

Are you fasting? This means you have NOT had anything to eat or drink other than water or coffee/tea without sugar or cream in the last 9-12 hours. Yes No
Note: If you have not fasted you may still participate; however, some of your measurements may be affected.

| | | | | | | | |
|-----------------|--------|---------|--------|----------------|----|--------------|--|
| Height: | inches | Weight: | pounds | Waist: | NA | Cholesterol: | |
| HDL: | | LDL: | | Triglycerides: | | Glucose: | |
| Blood Pressure: | / | A1C: | NA | Cotinine: | NA | | |

Section 2: PREVENTIVE PHYSICAL VALIDATION (required) – Primary Care Provider must indicate date of preventive physical and sign.

| | |
|---------------------------------------|------------------------------|
| Primary Care Provider Name: | Clinic/Practice Name: |
| Primary Care Provider Address: | Telephone Number: |

Patient completed a preventive physical on _____ **(enter date of Preventive Physical; must have date to get Wellness Incentive)**

Primary Care Provider Signature: _____ **Date of Signature:** _____