Preventive Care Health Information Form

All forms are due by 8/31/2025

oswaldthrives

Directions for Participant: Bring this form with you to your preventive care visit and fill out the section(s) below. ALL completed forms (with or without biometrics) should be submitted to the "Upload Preventive Care Form HERE" step in the PeopleOne Health portal or faxed to PeopleOne Health at (855) 434-8262 by 8/31/2025. **Keep a copy of your form for your record and follow-up with your provider to make sure the form has been submitted. Return of your completed form by the deadline is your responsibility, not your doctor's! Please ensure receipt of completed form by checking your PeopleOne Health portal for confirmation points have been awarded.**

SECTION 1 (REQUIRED): Preventive Care Confirmation (20 Tokens)
SECTION 2 (OPTIONAL): Meet 3 of 5 Biometric Values (5 Tokens)

PARTICIPANT NAME: _____
Last Name *First Name*

DOB *(mm/dd/yyyy):*_____/_____/_____ **SEX** *(as listed on birth certificate):*_____

SECTION 1: PREVENTIVE CARE CONFIRMATION (REQUIRED)

Provider: I hereby acknowledge that the undersigned patient is up-to-date with recommended preventive care.

_____ _____ _____
Provider Signature License # Date (mm/dd/yyyy)

_____ _____
Provider Name (Printed) Provider Phone Number

SECTION 2: BIOMETRIC VALUES (OPTIONAL)

Directions for Provider: Complete biometric values for the participant listed above from current bloodwork dated after 9/1/2024. If biometric values are obtained after the preventive care visit, please return the completed form to the participant to upload to the PeopleOne Health portal or fax this form to PeopleOne Health at (855) 434-8262. To receive credit for biometric values, the participant must meet at least 3 of the following values: **1.** Waist Circumference *OR* BMI **2.** Blood Pressure **3.** Fasting Glucose **4.** HDL **5.** Triglycerides

BIOMETRIC VALUE GOALS

Health Measures	Health Goals	
BMI	< 27.5 kg/m^2	
Waist Circumference	Male	Female
	< 40 in.	< 35 in.
Blood Pressure	< 130/85 mmHg	
Fasting Glucose	< 100 mg/dL	
HDL	Male	Female
	≥ 40 mg/dL	≥ 50 mg/dL
Triglycerides	< 150 mg/dL	

PARTICIPANT BIOMETRIC VALUES

Height _____ ft. _____ in. Weight _____ lbs. BMI _____
(measured to nearest 1/4 in.) *(measured to nearest 1/2 lb.)*

Waist Circumference *(measured to nearest 1/4 in.)*	_____ in.
Blood Pressure	_____/_____ mmHg
Fasting Glucose	_____ mg/dL
HDL	_____ mg/dL
Triglycerides	_____ mg/dL

PARTICIPANT SIGNATURE (REQUIRED)

Participant: I hereby certify that the information on this form is accurate to the best of my knowledge and I authorize this data to be provided to PeopleOne Health for the purpose of administering the sponsored wellness program ("Program"). I authorize Oswald, PeopleOne Health and/or other partners engaged in Oswald's health plan to conduct services in connection with the Program. Biometric measures are not required to participate in the Program. My results will be securely and confidentially handled by PeopleOne Health. I authorize the use and disclosure of my health and personal information for purposes of participation in the Program. I understand Oswald may determine my health plan payroll contributions, incentives and/or rewards based on: a. my participation in the Program; and/or b. the results of my biometric measures. Although Oswald may know how many categories I passed or failed, specific results will not be shared directly with Oswald. This Program is not a diagnostic tool; it does not provide, nor is it a substitute for, professional medical advice, diagnosis or treatment. The information provided by the Program is for educational purposes only and should not be interpreted as a diagnosis or as a recommendation for a specific treatment plan, product or course of action. This authorization will expire 12 months from the date of my new medical plan year or one year from date of this document, whichever is later. Refer to Oswald for more information to determine the impact on your health plan payroll contributions, incentives and/or rewards. I understand that it is my responsibility to make sure PeopleOne Health receives my completed form.

_____ _____
Participant Signature Participant Name (Printed)

_____
Participant Email

Upon obtaining your primary care provider's signature, please sign and return this form to PeopleOne Health for confidential tracking. The validity of this form may be verified for authenticity. Falsification of information will be subject to disciplinary actions consistent with employee guidelines. If you have any questions, please speak with your Human Resources representative.

All completed forms must be submitted to PeopleOne Health by 8/31/2025. Do not return this form to your employer.