Well-being Program Appeal Process

Eligible associates that are medically unable to participate in the Well-being Program due to unique circumstances may have a Licensed Medical Professional waive individual program components or the program in its entirety.

INSTRUCTIONS FOR APPEAL

- The Associate Information section of the Well-being Program Alternative Waiver should be filled out by the associate.
- The remainder of the form must be completed and signed by a Licensed Medical Professional.
- Upon completion, the associate or the Licensed Medical Professional submits the waiver by mail, fax or email:

WoodmenLife
Attn: Benefits Department
1700 Farnam St.
Omaha, NE 68102

Phone: 800-328-2968 ext. 57047
Secure Fax: 402-449-7781
Secure Email: Benefits_Mailbox@woodmen.org

APPEAL DEADLINE: September 30, 2021

The WoodmenLife Benefits Department must receive the completed Well-being Program Alternative Waiver no later than: **September 30, 2021**.

WoodmenLife's Benefits Department will evaluate the appeal to verify that all necessary information is complete. Incomplete forms will not be approved. The outcome of the appeal will only apply to the applicable plan year. This process must be completed for each new well-being program year.

Well-being Program Alternative Waiver

TO BE COMPLETED BY WOODMENLIFE ASSOCIATE

Associate Information (Please Print)

First Name | Middle Initial | Last Name | SS#

Date of Birth (mm/dd/yyyy) | Email Address | Associate ID#

By submitting, I verify that the information I have supplied is true and complete, and there has been no attempt to knowingly provide any false, incomplete, or misleading information.

Associate Signature | Date

TO BE COMPLETED BY A LICENSED MEDICAL PORIFESSIONAL

WAIVED PROGRAM COMPONENT(S) **Program may include but not limited to:** **Indicate by ☒**	**Brief explanation of why the component(s) cannot be completed (REQUIRED)**	**INTERNAL USE ONLY**
☐ Biometric Screening – includes blood pressure, cholesterol, glucose and BMI.		☐ Approved ☐ Denied

Licensed Medical Professional Name (print):	Licensed Medical Professional Signature:
License Type/Number:	City/State:
Phone Number:	Today's Date:

Appeal Review – Internal Use Only:	
Name:	
Signature:	Date: