



WELLNESS PROGRAM ACKNOWLEDGEMENT AND DECLINATION FORM FOR RETIREES AND SPOUSES

I, (print full name) _____, hereby
acknowledge and understand that I am waiving my rights to participate in the Wellness
Program, which includes the following:

- Confidential Health Risk Assessment, Biometric screening and Coaching session(s). All medical information is personal and confidential, as protected by federal law. Forsyth County does **NOT** have access to your individual results.
- **For Retiree-Only Coverage:**
\$60.00 per pay month deduction on my medical premium which equates to an annual savings of \$720.00 if I participate and comply with the wellness program.
- **For Retiree Plus One or Family Coverage (that includes a spouse):**
\$100.00 per month (\$60.00 for retiree and \$40.00 for spouse) on my medical premium which equates to an annual savings of \$1200.00 if both my spouse and I participate and comply with the wellness program.

Please check the appropriate box(es) below to decline participation:

- Retiree Not Participating
 Spouse Not Participating
 Retiree and Spouse Not Participating

Signature _____

Date _____

***Please return the completed form to Forsyth County Human Resources by
April 16, 2018***

You may make a copy for your records.