



# Phoebe

## 2026 Wellness Program

### To be Eligible:

Complete a Wellness Preventative Physical. Have the Physician complete verification form and submit to Human Resources Dept. to **earn a bi-weekly payroll credit.** *[This will not change your medical deduction, but will show as “Health Discount” - a separate line on paycheck.]*

- **Employee Only \$20**
- **Employee & Spouse \$40**

### **Wellness Physical Required**

Complete a wellness physical exam with your doctor and return verification form.



### **HealthiestYou (Telemedicine Benefit) Recommended**

Three Options:

- Download the HealthiestYou app. Select “First Time Here”, then select “Employee” as membership type. Register and complete Medical History.
- Online registration at <https://member.healthiestyou.com/user/sign-in>. - Select “Register Now”, enter Name, DOB, & Zip Code to create account login.
- Registration can also be done by phone at (866)703-1259 x 1.



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### PREVENTATIVE HEALTH SCREENING VERIFICATION INSTRUCTIONS

To satisfy the Preventative Health Screening Verification requirement for the 2026 Wellness Program, please do the following:

**Instructions for the Employee or Covered Spouse:**

1. Take these instructions along with the Health Screening Verification form to your preventative physical appointment.
2. Complete the top portion by printing YOUR name clearly as the Employee or Spouse and writing the date in which you had your physical completed.
3. Sign YOUR name on the Employee/Spouse Signature line. This serves as your personal verification.

**Instructions for the Physician:**

As the attending Physician of the preventative screening physical exam for our employee or covered spouse:

1. Please print your full first and last name along with the address where you provided the employee or covered spouse's examination at. You may include the phone number if you wish.
2. Please sign on the indicated line. If your medical practice has an official stamp, please also use it here. **SUBMIT THE PREVENTATIVE HEALTH SCREENING VERIFICATION FORM.**

Please return the form to **HR Benefits Specialist, Kim Fritzinger 610-794-5176**

Via **e-mail** [Benefits@Phoebe.org](mailto:Benefits@Phoebe.org), **Fax** 610-794-5420, or **in-house** at HR Mailbox #21

(OR provide to your facility's Human Resources Business Partner who will forward to above)



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### PREVENTATIVE HEALTH SCREENING VERIFICATION FORM

I \_\_\_\_\_ certify that I was seen by

(Please **PRINT** Your First Name, Middle Initial, Last Name as Employee or Spouse)

my physician on \_\_\_\_\_ (**Date**) to obtain my annual health screening.

X \_\_\_\_\_

(Phoebe Employee /Spouse Signature)

(**Date**)

This form reflects information for the following individual: (please check one)

**Enrolled Employee OR**     **Enrolled Spouse\***

\*If you are the Spouse of a Phoebe employee, please print Employee full name:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

#### Physician's Full Name & Address

X \_\_\_\_\_

#### Physician's Signature and Office Stamp, if available

Please return the form to **HR Benefits Specialist, Kim Fritzinger** 610-794-5176

Via **e-mail** [Benefits@Phoebe.org](mailto:Benefits@Phoebe.org) , **Fax** 610-794-5420, or **in-house** at HR Mailbox #21

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