

Healthy For Life (HFL) Self-Study
Incentive Application Form

1. Policy Holder Information

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|---------------------------|--|
| Policy Holder Name: _____ | Last 4 digits of Social Security: X X X - X X - _____ |
|---------------------------|--|

2. Member Applying for Incentive

Member Name: _____ Date of Birth: ____/____/____

Mailing Address: _____, City _____, State _____, Zip Code _____

Phone Number: (____) _____

E-mail Address: _____

3. Taxable Benefit

This incentive is a taxable benefit. Incentives earned by active employees, legislators, and/or their covered dependents will be processed as an off-cycle paycheck to the employee or legislator, separate from the bi-weekly paycheck if applicable. The total incentive will be reported as taxable income on the W-2. Retirees and/or their covered dependents will receive a check. Incentives paid to retirees will be reported as miscellaneous income and a 1099 will be issued at the end of the tax year.

Please initial you have read and understand the preceding statement. _____

4. Required Documentation

Please send copies of all documentation, not originals, as they will not be returned to you.

Weight Loss Record
 Applicants must show a 10% weight loss or a normal BMI at program completion. Documentation must be attached showing weight measurements from a health screening or doctor's office; one from before or at the start of the program and one within 6 months after program completion.

Program Participation Record
 Applicants must have completed at least 16 of the webinars. Members are asked to complete a Survey Monkey survey for each session completed. Upon receipt of this form, HCBD will verify if the member has completed at least 16 of the surveys and that the date completed is not all at once.

Physical Activity Record
 Applicants must show engagement in regular physical activity. Documentation may be a copy of a typical week from an exercise log, gym attendance, or a written and signed statement outlining a typical week's worth of physical activity.

5. Requesting Member, please sign and date:

I certify by signing this form all information on this form and any additional documentation provided is true and correct. I understand my request will be denied if I have not attached all required documentation or if I have already received the Healthy Weight Incentive this plan year. By reporting data for this health action, I am certifying the accuracy of the information provided, agreeing to audits, and have the responsibility to retain proof of all requirements.

Signature: _____ Date: _____



Return to:

Health Care & Benefits Division (HCBD):
 Fax: (406) 444-0080; Email: benefitsquestions@mt.gov; OR
 Mail: P.O. Box 200130, Helena, MT 59620-0130
 Telephone: (800) 287-8266, TTY Hearing Impaired: (406) 444-1421



For Office Use Only:

| | | |
|--|----------------------------------|-----------------------------|
| Member of State Plan: Employee ID: _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Record showing 10% weight loss | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| The participant has completed at least 16 surveys for webinars | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Physical Activity Record is attached | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Approval Signature & Date: _____ | Approval Signature & Date: _____ | |

The State Plan offers the incentive program to all plan members and their enrolled spouse/domestic partner. If you think you may be unable to meet a standard of the incentive program, you may qualify for an alternative program or different means to earn the incentive. You must contact the Health Care & Benefits Division (HCBD) as soon as possible at (800) 287-8266, TTY (406) 444-1421, or email benefitsquestions@mt.gov. We will work with you (and if you wish, your doctor) to design a program with the same incentive that is right for you.

We will maintain the privacy of your personally identifiable health information. Medical information that personally identifies you and that is provided through the incentive program will not be used to make decisions regarding your employment. Your health information shall only be disclosed to carry out specific activities related to the incentive program (such as responding to your request for a reasonable accommodation). You will not be asked or required to waive the confidentiality of your health information to participate or to receive an incentive. Anyone who receives your information for purposes of providing you services through the incentive program will abide by the same confidentiality requirements.

We securely maintain all electronically stored medical information we obtain through the incentive program, and will take appropriate precautions to avoid a data breach. If a data breach does occur involving information you provided to us for the incentive program, we will notify you immediately.

A copy of the Plan's privacy notice is available on the HCBD website or by going to <http://benefits.mt.gov/Portals/59/Documents/hipaa%20notice.pdf>.

Language Assistance – General Taglines

State of Montana is required by federal law to provide the following information.

- ملحوظة: إذا تكد تحدثت اذرك اللغة، فإن خدمات الممعدسة اللوغيتيتو توفر لك ابلامجن. التصريم 1063-999-855-1 رقم. م: بكهافتة الصم وال
- 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-999-1062 (TTY：1-855-999-1063)
- ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-999-1062 (TTY: 1-855-999-1063).
- ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-999-1062 (TTY: 1-855-999-1063).
- ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-999-1062 (ATS: 1-855-999-1063).
- ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-999-1062 (TTY: 1-855-999-1063).
- ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-999-1062 (TTY: 1-855-999-1063).
- 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-999-1062 (TTY: 1-855-999-1063) まで、お電話にてご連絡ください。
- 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-999-1062 (TTY: 1-855-999-1063) 번으로 전화해 주십시오.
- UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-999-1062 (TTY: 1-855-999-1063).
- ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-999-1062 (TTY: 1-855-999-1063).
- ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-999-1062 (телетайп: 1-855-999-1063).
- ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-999-1062 (TTY: 1-855-999-1063).
- PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-999-1062 (TTY: 1-855-999-1063).
- CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-999-1062 (TTY: 1-855-999-1063).

State of Montana Non-Discrimination Statement: State of Montana complies with applicable Federal civil rights laws, state and local laws, rules, policies and executive orders and does not discriminate on the basis of race, color, sex, pregnancy, childbirth or medical conditions related to pregnancy or childbirth, political or religious affiliation or ideas, culture, creed, social origin or condition, genetic information, sexual orientation, gender identity or expression, national origin, ancestry, age, disability, military service or veteran status or marital status. State of Montana does not exclude people or treat them differently because of race, color, sex, pregnancy, childbirth or medical conditions related to pregnancy or childbirth, political or religious affiliation or ideas, culture, creed, social origin or condition, genetic information, sexual orientation, gender identity or expression, national origin, ancestry, age, disability, military service or veteran status or marital status. State of Montana provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). State of Montana provides free language services to people whose primary language is not English such as: qualified interpreters and information written in other languages. If you need these services, contact customer service at 855-999-1062. If you believe that State of Montana has failed to provide these services or discriminated in another way on the basis of race, color, sex, pregnancy, childbirth or medical conditions related to pregnancy or childbirth, political or religious affiliation or ideas, culture, creed, social origin or condition, genetic information, sexual orientation, gender identity or expression, national origin, ancestry, age, disability, military service or veteran status or marital status you can file a grievance. If you need help filing a grievance, John Pavao, State Diversity Coordinator, is available to help you. You can file a grievance in person or by mail, fax, or email: John Pavao, State Diversity Program Coordinator - Department of Administration State Human Resources Division, 125 N. Roberts, P.O. Box 200127, Helena, MT 59620, Phone: (406) 444-3984 Email: jpavao@mt.gov

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)