Healthy For Life (HFL) Self-Study

Healthy Weight Incentive Application Form

1. Policy Holder Information

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 3 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

Live Life Well

For Office Use Only:

Member of State Plan: Employee ID: __ __ __ __ __ __	☐ Yes	☐ No
Record showing 10% weight loss	☐ Yes	☐ No
The participant has completed at least 16 surveys for webinars	☐ Yes	☐ No
Physical Activity Record is attached	☐ Yes	☐ No

Approval Signature: _____ Date: _____

The State Plan offers the incentive program to all plan members and their enrolled spouse/domestic partner. Please use your discretion when considering the information provided in these programs and talk to your doctor as needed prior to making any changes. 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 benefits.mt.gov/_docs/Documents/hipaa-notice.pdf.

State of Montana Non-Discrimination Notice - The State of Montana Benefit Plan 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. 45 C.F.R. § 92.8(b)(1) and (d)(1)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-270-3877 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-270-3877 (TTY: 711).

Language Assistance – General Taglines

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

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-270-3877 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-270-3877 (TTY: 711).

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 1-866-270-3877（TTY：711)。

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。1-866-270-3877 (TTY:711）まで、お電話にてご連絡ください。

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-270-3877 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-270-3877 (ATS : 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-270-3877 (телетайп: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-866-270-3877 (TTY: 711)**번으로 전화해 주십시오.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-668-072-7783 (رقم هاتف الصم والبكم: 117).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร1-866-270-3877 (TTY: 711).

MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 1-866-270-3877 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-270-3877 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-866-270-3877 (телетайп: 711).

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-866-270-3877 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-270-3877 (TTY: 711).