

IMPORTANT: To maintain BlueCHIP for Healthy Options' Advantage level benefits, this form must be completed and mailed to the address at right **no later than 240 days (eight months) after enrollment.** If we **do not receive** a Self-Reporting Form for each adult (aged 18 and older) family member within 240 days of enrollment, **the entire family will be enrolled in Basic level benefits.**

Small Group Underwriting - 00132
 Blue Cross & Blue Shield of
 Rhode Island
 500 Exchange Street
 Providence, RI 02903-2699

Member Name: _____

Member Identification Number: _____

Address: _____

Date of Birth: _____

To qualify for Advantage level benefits, you must confirm your participation in any necessary wellness program(s). Please fill in the appropriate information.

1. Smoker/Tobacco User Yes

I, _____,
MEMBER NAME
 confirm that I am participating in a smoking/tobacco cessation program.

Today's date is _____,
 and I understand my participation in the Advantage level of benefits is dependent on my engagement in this/these program(s).

Actions Taken: _____

Member Signature: _____

2. Smoker/Tobacco User No

I, _____,
MEMBER NAME
 confirm that I currently am not a smoker, yet I understand that if I start smoking and/or start using tobacco, I will participate in a smoking/tobacco cessation program.

Today's date is _____,
 and I understand my participation in the Advantage level of benefits is dependent on my compliance with this statement.

Member Signature: _____

3. Weight Management Yes, on my PCP Checklist, my primary care physician (PCP) recommended that I participate in a weight management program.

I, _____,
MEMBER NAME
 confirm that I am participating in the applicable weight management program(s) as directed by my PCP.

Today's date is _____,
 and I understand my participation in the Advantage level of benefits is dependent on my engagement in this/these program(s)

Actions Taken: _____

Member Signature: _____

4. Weight Management No, my PCP did not recommend that I participate in a weight management program.

I, _____,
MEMBER NAME
 confirm that I maintain a healthy weight, according to my PCP.

Today's date is _____,
 and I understand my participation in the Advantage level of benefits is dependent on my compliance with this statement.

Member Signature: _____



BlueCHIP for Healthy Options complies with the Rhode Island Office of the Health Insurance Commissioner's (OHIC) requirements for a HEALTHpact plan. HEALTHpact plans are designed to assist small employers in offering health coverage that encourages members to make healthy lifestyle choices by meeting certain Wellness Participation Requirements.

You can download blank Self-Reporting Forms from BCBSRI.com.



www.BCBSRI.com

500 Exchange Street • Providence, RI 02903-2699

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