EMPLOYEE HEALTH PLAN TOTAL CARE WELLNESS PROGRAM APPLICATION

WEIGHT MANAGEMENT
(Cleveland Clinic Tier 1 Program)

Member Name: ________________________________ *Medical ID Card Number: EHP*__________________

Employee Name: _______________________________ *Employee ID Number*_________________________

(must include if dependent is joining)

Address: ___________________________*City:*________________________*State:*__________*Zip:* _________

Home Phone: (_______)_________________ *Work Phone:* (______)_______________ *Ext:* ______

Email Address: _____________________________

1. Cleveland Clinic Tier 1 Program: ____

   *Location/Address:*____

2. *Current Program Start Date:* ______/_____/______

3. For verification of meeting attendance and future cost sharing by Cleveland Clinic, please note that you MUST return this application form within 10 days of your start date. Failure to complete this application will result in non-payment of the program and financial responsibility will become the member's.

MAIL OR FAX COMPLETED FORM TO:
Cleveland Clinic
Employee Health Plan
3050 Science Park Drive, AC332b
Beachwood, OH 44122
***Mail code** for internal mailings: AC332b*
***Fax numbers**: EHP Wellness: 216.448.2055*
Phone: 216-448-2247

AUTHORIZATION FOR RELEASE OF INFORMATION

I am in agreement to provide my height, monthly weigh-in status, and meeting attendance records as required. *I understand this information is necessary for payment of the program. This information is completely confidential and will ONLY be used to report program success in the aggregate. . I understand that payment of program fees by Cleveland Clinic will terminate upon termination of employment, if I cease to be a member of the EHP, or if I do not meet program requirements.*

Employee/Participant signature:____

NOTE: Incomplete forms will be returned for completion and payment for program will not be made unless the form is returned.