

# 2018 EMHS BIOMETRIC EXEMPTION FORM

(APPLIES IF CURRENTLY BREASTFEEDING OR PREGNANT)

## DECLARATION

I, \_\_\_\_\_ Employee's Name (Please print) \_\_\_\_\_ Employee ID

certify that I and/or my spouse/domestic partner qualifies for a 2018 medical exemption from **EMHS Biometric** reward requirements, in accordance with the criteria listed in the criteria section below.

EMHS organization (TAMC, Inland, etc.) \_\_\_\_\_

## PARTICIPANTS

This exemption applies to:

- Employee Name (Print) \_\_\_\_\_ DOB: \_\_\_\_\_
- OR
- Spouse/Domestic Partner Name (Print) \_\_\_\_\_ DOB: \_\_\_\_\_

## CRITERIA

I or my spouse/domestic partner:

- Is a participant in the 2017/2018 EMHS Employee Health Plan
- AND
- Has been pregnant within the last 3 months, is currently pregnant, or is breastfeeding

## ACKNOWLEDGMENTS

- This exemption applies to the:
  - Ⓐ Biometric screening
  - Ⓐ BMI-associated HRA reward.
- I affirm that the information in this statement is true and complete.
- I understand that knowingly making a false statement is a violation of the EMHS Code of Conduct, and as such may lead to discipline, up to and including termination of employment when deemed appropriate.

## SIGNATURES

\_\_\_\_\_  
Employee's Signature (required for both employee and/or spouse/domestic partner exemption)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Spouse/Domestic Partner Signature (only required if submitting for spouse/domestic partner exemption)

\_\_\_\_\_  
Date

Please submit all completed affidavits to **Beacon Health**:

**Fax:** (207) 989-1096

**Email:** beaconwellness@emhs.org

**Mail:** Beacon Health Wellness, 797 Wilson Street, Brewer, ME, 04412

