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 2018/2019 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) 973-7165
Email: beaconwellness@emhs.org

Beacon Health
EMHS MEMBER℠