Northern Light Beacon Health Employee Health Plan

NORTHERN LIGHT HEALTH BIOMETRIC PROGRAM EXEMPTION FORM
(APPLIES IF CURRENTLY BREASTFEEDING OR PREGNANT)

DECLARATION

I, _____ _____
Employee's Name (Please print) Employee ID

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

Northern Light organization (TAMC, Inland, etc.) _____

PARTICIPANTS

This exemption applies to:

- Employee Name (Print) _____ DOB:_____

OR

- Spouse Name (Print)_____ DOB:_____

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I or my spouse:

- Is currently a participant in the Northern Light Health 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 Northern Light Health 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 exemption) Date

_____ _____
Spouse Signature (only required if submitting for spouse exemption) Date

Please submit the completed affidavit to **Beacon Health** ***no later than November 30, 2019***.

Fax: (207) 973-7165
Email: beaconwellness@northernlight.org