AUTOMOTIVE INDUSTRIES WELFARE FUND

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2021 WELLNESS PROGRAM – EXAM CERTIFICATION FORM

LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER

MAILING ADDRESS (STREET OR P.O. BOX)	SEX (M/F)	DATE OF BIRTH

CITY	STATE	ZIP	MAIN NUMBER	MOBILE NUMBER
			( ) -	( ) -

E-MAIL ADDRESS	

MARITAL STATUS	EMPLOYER	DATE OF HIRE
☐ SINGLE ☐ MARRIED ☐ DOMESTIC PARTNER ☐ DIVORCED	OCCUPATION/CLASSIFICATION:	LOCAL #

PERSONAL & DEPENDENT INFORMATION

RELATION	LAST NAME	FIRST NAME	M.I.	SEX	DATE OF BIRTH
SELF					
□ SPOUSE □ DOMESTIC PARTNER**					

Certification of Participant

BY SIGNING IN THE AREAS SPECIFIED BELOW, I AM CERTIFYING THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT THE PURPOSE OF THIS FORM IS SOLELY FOR THE 2021 WELLNESS PROGRAM EXAM CERTIFICATION AND CANNOT BE USED FOR ANY OTHER ENROLLMENT PURPOSE, INCLUDING, BUT NOT LIMITED TO: CHANGE OF ADDRESS, CHANGE IN DEPENDENTS, CHANGE IN MARITAL STATUS, OR CHANGE IN MEDICAL PLAN OR SERVICE PROVIDER.

EMPLOYEE SIGNATURE: _____ **DATE**:_____

THE BELOW SECTION IS TO BE SIGNED BY YOUR MEDICAL PROVIDER.

PHYSICIAN CERTIFICATION

THIS WILL CERTIFY THAT THE BELOW NAMED PARTICIPANT IN THE AUTOMOTIVE INDUSTRIES WELFARE PLAN WAS SEEN IN MY OFFICE AND RECEIVED A ROUTINE PHYSICAL EXAMINATION AND LABORTORY SCREENING.

PATIENT'S NAME: _____ **DATE OF EXAM** :_____

PHYSICIAN'S SIGNATURE: _____ **DATE**:_____