

2026 HEALTH SCREENING FORM



I am (select one): a member enrolled spouse of a member **Questions? Call Heartland at 937.665.1900.**

HEALTH SCREENING

First Name _____

Last Name _____

Medical ID# _____

Last 4 digits of SS# _____

Email _____

Telephone _____

Street Address _____

City _____ State _____ Zip _____

I understand this form must be fully completed and legible to be processed. Results must be from a 2026 health screening to be eligible. **Please remember to fast 12 hours in advance.** By signing this form, I agree with the health screening results provided. I hereby authorize the medical health care provider and/or medical facility to release the health data to the Fund's wellness and claims analysis providers and the Heartland Health & Wellness Fund.

SCREENING TEST	RESULTS	SCREENING TEST	RESULTS	SCREENING TEST	RESULTS
BMI		Blood Pressure		Total Cholesterol	
HDL Cholesterol		LDL Cholesterol		Triglycerides	
Blood Glucose		Notes:			

(Signature of person screened)

Date of Screening

(Print name of in-network provider)

(Signature of in-network provider)



You are responsible for returning this completed and signed form to the Fund office.

EMAIL	MAIL	FAX
wellness@ufcwbenefitplan.com	Attn: The Wellness Department Heartland Health & Wellness Fund 7250 Poe Avenue, Suite 300 Dayton, OH 45414	937.910.0600