**Healthy Opportunities Participation Election**

**Employee Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Last Four of SSN** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Department** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**E-Mail Address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The State of Iowa invites you to participate in the Healthy Opportunities Wellness Program. The program seeks to promote and support health awareness, individual responsibility for a healthy lifestyle, decreased risk of disease and enhanced quality of life. Your participation in the program is encouraged by reducing your share of the health insurance premium.

You have a limited amount of time to complete the program’s requirements. You have 30 days from the effective date you first become the health insurance contract-holder and you are in a wellness-eligible position (i.e., start date, date of your promotion, transfer, reclassification, or demotion to a wellness-eligible position) to complete this form and elect to participate in the Healthy Opportunities Wellness Program. You have an additional 60 days (90 days total) to complete the program requirements, consisting of a biometric screening and online health assessment.

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| **To be completed by the Human Resources Associate:****Reason for Eligibility for the Healthy Opportunities Wellness Program**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| [ ]  New Hire | [ ]  Promotion | [ ]  Demotion | [ ]  Transfer | [ ]  Reclassification  | [ ]  Life Event \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  Effective Date of the Event \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Biometric screening and online health assessment completion deadline:** \_\_\_\_\_\_\_\_\_\_\_HRA: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HRA email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Please give a copy of the completed form to the employee, keep a copy of this form in the employee’s personnel file; and send the original to DAS-HRE, Attn: Wellness Specialist. |

I elect to:

[ ]  **Participate** in the Healthy Opportunities Wellness Program

[ ]  **NOT Participate** in the Healthy Opportunities Wellness Program

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| --- |
| If I elect to participate in the Healthy Opportunities Wellness Program:* I agree to complete all of the requirements of the Healthy Opportunities Wellness Program in order to receive the reduction in my health insurance premium.
* If I do not complete all of the Healthy Opportunities Wellness Program requirements within the designated timeframe indicated above, DAS will reverse my health insurance election so that I will contribute 20% of the total premium. Also, I will be responsible for the difference in my previous deductions and the 20% contribution.
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SIGN HERE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **DAS HRE USE ONLY**

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| Date received in DAS-HRE |  |

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