



EMPLOYEE HEALTH PLAN TOTAL CARE WELLNESS PROGRAM APPLICATION

WEIGHT MANAGEMENT (Weight Watchers®)

Member Name: _____	Medical ID Card Number: EHP _____
Employee Name: _____ (must include if dependent is joining)	Employee ID Number _____
Address: _____	City: _____ State: _____ Zip: _____
Home Phone: (____) _____	Work Phone: (____) _____ Ext: _____
Email Address: _____	

NEW MEMBER RENEWAL

Location/Address: _____

Check One

Length of Session Signed Up For (**check one**)
(Participation Requirements for Weight Watchers)

- | | | |
|---|---|--|
| <input type="checkbox"/> Weight Watchers At Work: | <input type="checkbox"/> Meeting Attendance (10 of 13) or | <input type="checkbox"/> Meeting Attendance (15 of 18) |
| <input type="checkbox"/> Weight Watchers Community: | <input type="checkbox"/> Meeting Attendance (10 of 13) or | <input type="checkbox"/> Meeting Attendance (15 of 18) |
| <input type="checkbox"/> Weight Watchers Online: | <input type="checkbox"/> 10 Weeks – 3 months or | <input type="checkbox"/> 32 Weeks - 12 months |

2. Current Program Start Date: ____/____/____

3. For verification of meeting attendance and future cost sharing by Cleveland Clinic, please note that you MUST return this application form within 10 days of your series start. At Work participants turn in at informational meeting. All others, mail to the address listed below:

MAIL COMPLETED FORM TO:
Cleveland Clinic
Employee Health Plan Total Care
3050 Science Park Dr. AC332b, ATTN: EHP Wellness
Beachwood, OH 44122
Phone: 216-448-0800

Faxes cannot be accepted as an original signature is required.

AUTHORIZATION FOR RELEASE OF INFORMATION

I am in agreement to provide my height, monthly weigh-in status, and meeting attendance records as required by sending a copy of the inside of my Weight Watchers Membership Booklet to Cleveland Clinic Employee Health Plan Total Care at the end of each session for verification of participation in the program. I understand this information is necessary for payment of the program. This information is completely confidential and will ONLY be used to report program success in the aggregate. I understand that payment of program fee or incentive by Cleveland Clinic will terminate upon termination of employment, if I cease to be a member of the EHP, or if I do not meet program requirements.

Employee/Participant signature: _____ Date: _____

NOTE: Incomplete forms will be returned for completion and payment for program will not be made unless form is returned.