Sibanye-Stillwater

Wellness Confirmation Form

Dear Healthcare Provider:

The Sibanye-Stillwater Health Plan is promoting a voluntary, preventive care wellness incentive for employees and spouses (if applicable) on our medical plan. Due to the significant role that preventive care plays in staying healthy, we are encouraging health plan members to utilize the preventive services available to them through our medical benefits.

Please discuss a preventive care plan with the member and ensure that they are up-to-date on preventive care screening tests, exams, and immunizations, as well as discuss lifestyle changes that will improve their health and prevent disease.

This form is proof of completion of a preventive physical exam and/or biometric screening by a medical practitioner. Please complete the Health Care Provider section and return it to the member. They are responsible for turning the completed form in to Sibanye-Stillwater Human Resources by December 31 each year.

Healthcare Providers

- *Routine adult "preventive" physical exams, screenings, and labs are covered at 100% and are not subject to co-pays or deductibles if performed by an in-network provider of the Sibanye-Stillwater Health Plan. It is the member's responsibility to determine if he/she is utilizing an in-network provider for the health plan.*
- *Please verify when submitting claims that "preventive" codes are used to ensure the services are reimbursed properly. If a medical diagnosis is found during this preventive exam, please inform the participant that a portion will be submitted to their insurance as such and subject to deductible and co-insurances.*

HEALTHCARE PROVIDER Confirmation:

Healthcare Provider Name (Printed): _____

Healthcare Provider Signature: _____

Healthcare Provider's Practice and phone #: _____

Patient Name (Printed): _____

Preventive exam completed: ☐Yes, date:_____ ☐No

Biometric screening completed: ☐Yes, date:_____ ☐No ☐Not medically necessary _____(Provider initials)

PARTICIPANT Acknowledgment:

Participant name - Printed: _____ Signed: _____

Email: _____ Phone: _____ Date: _____

☐I am an employee and covered by the Sibanye-Stillwater health plan, Employee number: _____

☐I am the spouse of an employee and covered by his/her health plan, Spouse's Employee Number: _____

Notice to Participant: Completed forms may be faxed to (406) 932-8340, returned to your site HR Office, or emailed to ColHRFrontDesk@sibanyestillwater.com by December 31 each year.

Upon obtaining your health care provider's confirmation, please complete participant's section and return this form to HR for confidential tracking. The validity of the provider's signature and exam date may be verified for authenticity. Intentional falsification of information will be subject to disciplinary action consistent with employee guidelines up to and including termination of employment. If you are unable to participate in any of the health-related activities required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting HR at ColHRFrontDesk@sibanyestillwater.com.