



DISNEY PREVENTIVE EXAM FORM

Well-Being Rewards Program

Use this form to report the completion of a preventive activity. If you are enrolled in a Cigna or Allegiance medical plan option, your preventive care claims will automatically qualify you for your preventive well-being reward. Any participants may use this form to report biometric numbers. After filling in the information below, to get credit for your activity, you may send this form to:

Mail: Cigna Customer Service, PO Box 5201-5201, Scranton, PA 18505.

Online: Upload your form at myCigna.com

Fax: Enter "Confidential" on the Fax Cover Sheet and fax this form to **888.467.7281**.

Note: In order to receive credit for your activity, you must complete all demographic information, and select the applicable preventive exam. Before you see your health care provider and obtain a signature as verification of completion, you must check the preventive care activity you plan to complete.

Please print

First name:	Last name:			M.I.:
Work phone:	Account number: 3207160	Date of birth (MM/DD/YY): / /	Social Security number (last 4) □ □ □ □	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female

Preventive care: (check one)

- Physical exam
 Mammogram
 Cervical cancer screening
 Prostate cancer screening
 Colonoscopy
 OB/GYN
 Skin Cancer Screening

Screening Information (biometrics preferred, but not required)

Date / /

BMI □ □ □	OR	Height/weight (required) Feet <input type="text"/> <input type="text"/> Inches <input type="text"/> <input type="text"/> Pounds <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Waist circumference Inches <input type="text"/> <input type="text"/>	Blood pressure Systolic <input type="text"/> <input type="text"/> <input type="text"/>	Diastolic <input type="text"/> <input type="text"/> <input type="text"/>	Triglycerides mg/dl <input type="text"/> <input type="text"/> <input type="text"/>
Fasting blood sugar mg/dl <input type="text"/> <input type="text"/> <input type="text"/>		A1C <input type="text"/> <input type="text"/> . <input type="text"/> %	Total cholesterol mg/dl <input type="text"/> <input type="text"/> <input type="text"/>	LDL cholesterol mg/dl <input type="text"/> <input type="text"/> <input type="text"/>	HDL cholesterol mg/dl <input type="text"/> <input type="text"/> <input type="text"/>	

Doctor or Health Care Provider verification

Doctor/Health Care Provider's note: To get credit for the preventive care activity, individuals must complete one of the preventive care requirements noted above.

Your signature and date below is confirmation that the preventive care service noted above has been completed.

Date signed	Doctor/Health Care Provider signature	Date service completed (MM/DD/YY)

Good for you! Good health starts with preventive care.

Together, all the way.®



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