BIO26 – Biometric Screenings Form

FOR 2026 OPEN ENROLLMENT ONLY

BIO26 – PROVIDER DATA ENTRY FORM

GENERAL INFORMATION

PLEASE PRINT CLEARLY AND STAY WITHIN THE BOXES BELOW

PARTICIPANT (PERSON BEING MEASURED) INFORMATION – Completion required.
First Name: Must match the name on record for your health benefits.
Last Name:
Date of Birth: (MM/DD/YYYY)
Member U ID# Spouses/Domestic Partners have a distinct Member ID# that is separate from the Subscriber's Member ID#. Enter the Member ID# of the person being measured. If you do not know your Member ID#, you must complete the field for SSN below.
SSN: If you have entered your Member ID# above, you may leave the field for SSN blank.
Important: This form is ONLY for current UEBT/UCBT/PACT Members and Spouses/Domestic Partners who are completing their Wellness Steps for 2026 benefits.
If you are the Spouse of a Member, you <u>must</u> submit your completed GINA Agreement to the Trust Fund Office before completing and submitting this form
By submitting this form, I am authorizing my physician to report the laboratory and biometric results to UFCW & Employers Trust, LLC for my Biometric Health Screenings, and for UEBT/UCBT/PACT to collect such information. If I am a Participant in the UEBT/UCBT/PACT Plan because I am the Spouse of a Member, I further acknowledge that by agreeing to this authorization, I am providing information regarding my current or past health status (or manifestation of disease or disorder) and that I authorize the use of this information for the purposes described in the Biometric Screenings Instructions

- 1. Please review the Biometric Screenings Instructions to verify you need biometric screenings tests prior to having any done.
- 2. You, the Participant, are responsible for meeting all program deadlines. You, the Participant, must collect this form from your physician or clinician and submit to UFCW & Employers Trust, LLC, as prescribed. Only one physician form can be submitted per person.
- 3. See the program description in your enrollment materials for more details. Please keep a copy of this physician complete form for your records.

Participant's Signature:	 Date (MM/DD/YYYY):	

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Please upload this form to your Participant Account on <u>ufcwtrust.com</u>, or fax this form to 925-746-7549

For more information, call the UFCW Trust Fund Office Health and Welfare Services Department at 800-552-2400

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ENERAL INFORMATION		
Participant Last Name:		MEASUREMENTS AND LABORATO WORK MUST BE COMPLETED ON
ate of Birth (MM/DD/YYYY):		AFTER JANUARY 1, 2025
DR PROVIDER OR OFFICE STAFF USE	ONLY BELOW THIS LINE	
BODY MEASURE		NICOTINE USER?
Test Date (MM/DD/YYYY):	Height: (in.) Weight: (lb	os.)
Blood Pressure		
Test Date (MM/DD/YYYY):	Systolic Diastolic	
Glucose		
Test Date (MM/DD/YYYY):	Fasting Glucose: A -OR-	A1c (Fasting or Non-Fasting):
Cholesterol		
Test Date (MM/DD/YYYY):	HDL: LDL:	TRI: Total:
OTE: Facility and agent name must b	a printed in the boyos	
I certify these values are corre		
Facility Name:		
Certifying Agent First Name:		
Last Name:		
NPI#:		
NPI#: National Provider Identifier		
Today's Date: (MM/DD/YYYY)	Signatu	re: