



Healthy Baby Benefit

A balanced beginning for you and your baby

Congratulations on your pregnancy!

The Healthy Baby benefit is an incentive-based program which encourages early comprehensive maternity care. This benefit includes education on preparing for pregnancy, healthy behaviors during pregnancy, preventing pregnancy complications, depression and stress, dental care, and more.

What is covered under the benefit?

When you participate in the program, you are eligible to receive:

- \$500 if enrolled by the end of the 1st trimester **or**
- \$250 if enrolled by the end of the 2nd trimester

You must complete an enrollment form after your first prenatal visit. You and her doctor must complete a validation form after the postnatal visit following delivery, which will confirm that you have adhered to all recommended prenatal care.

Questions?

If you have questions about this benefit, we can help. Just call Meritain Health at the number on your ID card.



Wilson County Board Of Education
Healthy Baby Benefit Program
Enrollment Form

Complete and send form to:

Meritain Health®
P.O. Box 853921
Richardson, TX 75085-3921
Fax: 1.763.852.5057

You can also submit these forms
online through your Meritain
Health member portal.

Employee Name: _____
(Please Print)

Address: _____
(Street) (City) (State) (Zip)

Employee ID Number: ____ - ____ - ____

Patient Name: _____
(Please Print)

Relationship to Employee: _____

Patient ID Number: ____ - ____ - ____

Patient Date of Birth: _____

DATE OF FIRST OB/GYN VISIT: _____
(mm/dd/yyyy)

By completing and submitting this form, I am enrolling in the Healthy Baby Benefit Program and agree to adhere to all recommended pre-natal care instructions.

Signature: _____ Date: _____

Healthy Baby Benefit Program Claim Form



MERITAIN[®]
HEALTH
An Aetna Company

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Section 1. EMPLOYEE INFORMATION

Name (last, first, initial)				Sex	Employer Name	
Home Address				Identification Number		Birthdate
						Group Number
City	State	Zip Code	Work Telephone ()		Home Telephone ()	

Section 2. PATIENT INFORMATION

The patient is:	☐ The employee	☐ Employee's Spouse (Complete spouse information)	☐ Employee's Child (Complete spouse and child information)
Spouse's Name (last, first, initial)		Sex	Child's Name (first, last, initial)
			Sex
Spouse's Birthdate	Spouse's ID Number	Child's Birthdate	Child's ID Number
Spouse's Employer			
Spouse's Employer's Address			

EMPLOYEE'S (or adult dependent's) SIGNATURE REQUIRED

The statements above are true and correct to the best of my knowledge. I authorize any provider of services to furnish any information requested to the Benefit Administrator. I also authorize the Benefit Administrator to release or obtain from any organization or person information that may be necessary to determine benefits payable under the Benefit Plan. A photo-static copy of this authorization shall be considered as effective and valid as the original. For any payment that exceeds the amounts payable under the Benefit Plan, I agree to reimburse the plan in a lump sum payment or by an automatic reduction in the amount of future benefits that would otherwise be payable.

Signature:

Date:

ATTENDING PHYSICIAN STATEMENT

Patient Name (last, first, initial)	Date of First Pre-Natal Visit
Patient Date of Birth	Date of Post-Delivery Visit
Due Date	The above-named patient has complied with all recommended pre-natal care. ☐ Yes ☐ No

Date					Physician's name (Print)					Signature														
Degree					ID Number					Tax Identification No.														
Street Address					City or Town					State or Province					Zip Code					Telephone				