2026 Dodge County Wellness Program

Annual Physical & Biometric Affidavit Form

PARTICIPANT: Complete your information and bring this form to your provider for completion. To qualify for lower premium rates for the 2027 plan year, both you and your spouse (if covered by Dodge County's Insurance Plan) must complete an annual preventative care visit and biometric screen between **November 1, 2025, and October 31, 2026**.

PARTICIPANT INFORMATION

Employee Name (Required): _____

Patient Name (Print): _____ **Patient is:** ☐ **Employee** ☐ **Spouse**

ACKNOWLEDGEMENT: I understand that this document must be completed by both my provider and me and returned to Human Resources by **October 31, 2026**, in order to receive the lower premium for the 2027 plan year. I hereby certify that the information below is true and correct to the best of my knowledge. I further acknowledge and understand that if I knowingly and willfully make a false statement, I may lose the ability to retain the wellness contribution rate for my health coverage in the future plan years.

Patient Signature: _____ **Date:** _____

PLAN PARTICIPANT ATTESTATION

PART A: ANNUAL PREVENTATIVE CARE VISIT

☐ I hereby certify that I have completed an Annual Preventative Care Visit with my medical provider.

Annual Preventative Care Visit on: _____

PART B: BIOMETRIC SCREENING

☐ I hereby certify that I have completed an onsite biometric screening through GHT at the County.

Date of Screening: _____

☐ I hereby certify that I have completed a biometric screening at the time of my annual preventative care visit with my medical provider.

Date of Screening: _____

PHYSICIAN CERTIFICATION

I hereby certify that the above-named plan participant has completed an Annual Preventative Care Visit and/or a biometric screening as part of their annual preventative care.

Medical Provider Name: _____

Medical Provider Signature: _____ **Date:** _____

PLEASE RETURN THIS FORM TO HUMAN RESOURCES BY OCTOBER 31, 2026
E-mail completed form to: hr@co.dodge.wi.us