HOLSTON CONFERENCE
of The United Methodist Church

Annual Wellness Screening Form

Participant Name: _____ _____
First Name Last Name

Check One: ☐ Employee ☐ Spouse

BCBST ID Number: | H | C | U | | | | | | | | | |

PROVIDER COMPLETES THIS SECTION

Date of Wellness Exam: MM/DD/YYYY | | | | | | | | |

☐ **I certify that the member named above has completed an annual wellness exam.**

(check box)

Provider Name (Printed):	
Provider Signature:	
Provider Office Phone Number:	
Date:	

❖ **Please Return Completed Form to ONE of the following options:**

- **Mail to: Holston Conference Office of Pensions & Health Benefits, P.O. Box 850, Alcoa, TN 37701-0850**
- **Fax To: 865-690-3162**
- **Scan and Email to: kenluton@holston.org**

of Tennessee