

# Journeyman & Apprentices of Local 188 Health & Welfare Fund

c/o My Benefits Administrator, LLC

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## 2026 WELLNESS INITIATIVE

Directions: Provide this form to your treating physician for completion. Beginning January 1, 2027, in order for your Annual Medical Deductible to remain at \$1,000 (single) or \$3,000 (family), this form must be completed in its entirety by your treating physician and returned to the Fund Office by fax or secure email (see above for fax number or email address). **Note, for those members with family coverage, in order for your Annual Medical Deductible to decrease to or remain at the \$3,000 (family) level beginning January 1, 2027 (for your entire family), a wellness form must be completed in its entirety and submitted to the Fund Office for both the member and his/her spouse, if any. Note, the deadline for the Fund Office to receive this form is December 31, 2026. Retroactive changes will not be made.**

**THIS FORM MUST BE COMPLETED EVERY YEAR AND SUBMITTED TO THE FUND OFFICE BY THE DEADLINE IN ORDER TO MAINTAIN OR INITIATE THE LOWER SINGLE/FAMILY DEDUCTIBLE.** If you have any questions/concerns, contact the Fund Office by calling (912) 503-9008.

Member Name: \_\_\_\_\_

Last Four of SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**If this completed form is for the Member's Spouse, provide the following information:**

Spouse's Name: \_\_\_\_\_

Last Four of SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### To Be Completed by Physician

On \_\_\_\_\_ (date cannot be before January 1, 2026 to qualify),

\_\_\_\_\_ (Member or Spouse's name), had an annual routine examination performed in my office. Based on the results of the examination, I have referred him/her for appropriate diagnostic testing based on his/her age, sex, and health condition (if necessary).

Physician Name\*: \_\_\_\_\_

Physician Address: \_\_\_\_\_

Physician's Signature\*: \_\_\_\_\_

Date: \_\_\_\_\_

\*\*"Physician" includes Nurse Practitioner or Physician's Assistant.