AccordiaLife
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**Accordia Life and Annuity Company**
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Customer Contact Center –
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# Wellness for Life Program Rewards Qualification Form

*COMPLETE ALL SECTIONS (Please print or type all information except signatures. Please use black ink.)*

The ***Wellness for Life Program*** is a life insurance policy benefit established to encourage and reward healthy living. In order to qualify for potential wellness rewards, participating insureds must get a routine physical exam once every two years and manage his/her weight within a range established by Accordia at policy issue. **The purpose of this form is to provide Accordia with a verification that the insured received a routine physical, and the insured's weight, only. By signing below the insured is NOT authorizing Accordia to review the insured's medical records.**

*Instructions for Insured:* Complete this form and have it signed by your doctor/health care provider at your regularly scheduled routine physical. Return this form to the address of the company above.

*Notice to Insured:* In the event the insured is not the policy owner, submission of this form provides authorization to Accordia to share Wellness qualification status with the policy owner.

| Name of Insured: | Gender: ❑ Male ❑ Female | Birth Date: _____/_____/_____ ( mm / dd / yyyy ) |
|---|---|---|

Insured's Social Security Number: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Policy Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Insured's Address:

City: State: Zip Code:

Insured's Weight: _____ lbs.

**Attention Home Office:** If extenuating circumstances are listed below, code the weight as "9999".

Please indicate if the insured has any special physical conditions (e.g. pregnancy, body cast, etc.) or if there currently are extenuating circumstances that substantially affect the insured's measured weight.

Date of routine physical when above measurements were taken: _____/_____/_____ ( mm / dd / yyyy )

Name of Doctor:

Address of Doctor:

Signature of Doctor or authorized representative (nurse):

Date: _____/_____/_____ ( mm / dd / yyyy )

**Note:** All costs associated with any physical exams undergone to meet the ***Wellness for Life Program*** qualification criteria are the responsibility of the insured and/or policy owner.