UFCW LOCAL 1776 AND PARTICIPATING EMPLOYERS
HEALTH AND WELFARE FUND

BIOMETRIC SCREENING FORM

Submission Deadline: November 13, 2020

2021 OE

Section I: Patient Information *(please print clearly)*

First Name:

Last Name:

Gender:

Last Four of SSN:

Date of Birth:

Phone:

E-mail:

Spouse's Information (if applicable):
First Name:
Last Name:
Last Four of SSN:

Section II: To Be Completed By Physician - ALL INFO REQUIRED OR ELSE FORM WILL BE INCOMPLETE

Note: The Biometric Screenings must have been completed between November 1, 2019 and November 13, 2020. If you already completed your biometric screenings, simply ask your doctor to complete your Biometric Screening Form(s). Then, return it to the Fund office for receipt by November 13, 2020.

Date of Physical Exam

Date of Eye Exam

Date of Lab Collection

Where was Eye Exam Performed? (Name of Provider)

Height in Inches	Weight in Pounds	Blood Pressure Systolic	Blood Pressure Diastolic	Glucose

Total Cholesterol	HDL	Triglycerides	LDL	Cholesterol Ratio *(not required)*	A1C if indicated *(not required)*

Section III: Preventive Screenings

	Completed	Not Completed	Not Needed
Pap Smear (for women) within 3 years if 21 or older	☐	☐	☐
Mammogram (for women) within 1-2 years if 40 or older	☐	☐	☐
Prostate Cancer Screening (for men) 45 or older with family history	☐	☐	☐
Colorectal Screening (adults over 50) Fecal Occult Blood Test or Colonoscopy	☐	☐	☐

Is the Patient currently fasting? ☐ Yes ☐ No

Does the Patient smoke/chew/use tobacco products? ☐ Yes ☐ No

Physician's Name (First and Last)

Physician's Phone Number

Physician's or LIP's Signature

Date

Please return completed form, signed by your physician, to the Fund Office by November 13, 2020: *(Please keep a copy for your records)*

Mail: 3031 B Walton Road Plymouth Meeting PA, 19462
Fax: (610) 941-9602
Email: OpenEnrollment@UFCW1776benefitfunds.org
*You may also upload your form into the Document Center in your MemberXG account

For Fund Office Use Only:
REFERENCE #