Dear Participant,

Complete an annual exam and biometric screening through an in-network healthcare provider and earn wellness incentives simply for knowing your numbers!

- From Oct. 1, 2016 – March 31, 2017, you’ll earn the full incentive of $500 ($125/quarter)
- From April 1 – Dec. 31, 2017, you’ll earn a partial incentive of $125 per remaining quarter

Simply bring the attached Biometric Screening & Annual Exam Form to your healthcare provider. After completing the form, your doctor will email, fax or mail it to the address at the top of the form. Keep in mind, to earn the full incentive, your form must be received by Provant Health Solutions by March 31, 2017.

Can’t make it to your healthcare provider? Cargill is offering onsite biometric screenings to eligible employees* at locations across the U.S. from Jan. 1 - March 31, 2017. Beginning December 2016, learn more about Cargill’s 2017 biometric screening program, or view a complete list of scheduled onsite biometric screening events at:

- The MyHealth website at www.cargill.com/myhealth; or
- The Health and Wellness page on Cargill Connects’ HR Center

You’ll earn $200 simply for completing your onsite biometric screening, and you’ll also earn incentives for results that fall within the healthy ranges. If your blood pressure, cholesterol and body mass index fall within the healthy ranges, you’ll earn $100 per healthy outcome. If some or all of your results aren’t in the healthy ranges, don’t worry. There are other ways for you to earn incentives to reach the full incentive amount of $500. Beginning Jan. 1, 2017, visit the MyHealth website at www.cargill.com/myhealth for more information!

And remember, you also get $200 for being tobacco-free! Attest that you and your covered family members have not used tobacco in the past 12 months (or have completed a tobacco/smoking cessation program within the last 12 months) during the Open Enrollment process to earn a $200 incentive ($50 per quarter).

If you have any questions about the Biometric Screening & Annual Exam Form process, please contact Provant Health Solutions at 855-883-0368.

We hope you join us on this journey to good health!

Sincerely,
Cargill Human Resources

* Biometric screenings and wellness incentives are available for those covered under a Cargill medical plan that includes wellness incentives.
Biometric Screening & Annual Exam Form  

Please Note: This form is NOT a physician order

Participant: Please fill out and sign Section 1.

Healthcare Provider*: Please fill out and sign Section 2, and submit form.

<table>
<thead>
<tr>
<th>SUBMIT FORM TO:</th>
<th>IMPORTANT:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fax: (401) 236-6533</td>
<td>1. All information is required to process this form.</td>
</tr>
<tr>
<td>Mail: Cargill</td>
<td>2. The form must be received no later than December 31, 2017.</td>
</tr>
<tr>
<td>Attention: Data Department</td>
<td>3. Questions? Call the Provant Wellness Incentive Program Helpline:1-877-239-3557</td>
</tr>
<tr>
<td>PO Box 901</td>
<td></td>
</tr>
<tr>
<td>East Greenwich, RI 02818</td>
<td></td>
</tr>
<tr>
<td>Email: <a href="mailto:cargill@provanthealth.com">cargill@provanthealth.com</a></td>
<td></td>
</tr>
</tbody>
</table>

*For purposes of this form, “Healthcare Provider” includes a licensed health professional, for example: MD, DO, PA, or NP.

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**Section 1: Completed by participant**

Name: ________________________________

Date of Birth: (DD/MM/YYYY)

Gender: ☐ Male  ☐ Female  ☐ Other

Status: ☐ Employee  ☐ Spouse  ☐ Other

Employee ID: ____________________________

Phone Number: __________________________

Email Address: __________________________

**HIPAA AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:** I hereby authorize Provant Health Solutions, LLC and its affiliates, employees, agents, and contractors (collectively, “Provant”) to use and disclose my protected health information to the healthcare plan sponsor by my, or my spouse’s, employer, and/or any vendor with whom my, or my spouse’s, employer or Provant may contract for the purposes of health and wellness programming as set forth below. Effective Period: This Authorization shall be in full force and effect until the termination of my participation in my, or my spouse’s, employer’s health and wellness program or upon the termination of my, or my spouse’s, employer’s Provant administered health and wellness program, whichever is later, at which time this Authorization expires. Information Subject to Use or Disclosure: I understand that Provant may use and disclose any and all of the information obtained from the instant health screening pursuant to this Authorization. This information includes biometric data. Purposes of Disclosure: I understand that Provant may use and disclose the information subject to this Authorization for the purpose of administering my, or my spouse’s, employer’s health and wellness program. Right to Revoke: I understand that I have the right to revoke this Authorization by notifying Provant, in writing, at Provant, Attn: Data and Reporting, PO Box 901, East Greenwich, RI 02818, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my Authorization. I understand that, in the event that I revoke this Authorization, I may no longer be eligible to qualify for certain incentives that are contingent upon my participation in my, or my spouse’s, employer’s health and wellness program. Conditional Authorization: I understand that signing this Authorization is voluntary; however, my participation in my employer’s health and wellness program may be conditioned on my signing this Authorization. I understand that if I do not sign this Authorization, I, or my spouse, may not be eligible to obtain certain incentives, if any, from my, or my spouse’s, employer’s health and wellness program. By signing below, I acknowledge that I HAVE READ CAREFULLY and understand the above, and have had any questions explained to my satisfaction.

Signature: ____________________________

Date: (DD/MM/YYYY)

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**RELEASE OF LIABILITY:** I hereby release Provant, and all other organizations associated with this screening, parent and affiliated companies, successors and assigns, officers, directors, staff, and employees from any and all liability arising from my participation in this health screening. The information collected and entered by this form will be transferred to Provant for processing for the purposes of health and wellness programming via an express carrier (e.g., FedEx) and/or through data transmission. Provant disclaims any and all liability resulting from any approved entity’s use or loss of data so transmitted. By signing below, I acknowledge that I HAVE READ CAREFULLY and understand the above, and have had any questions explained to my satisfaction.

Signature: ____________________________

Date: (DD/MM/YYYY)

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**Section 2: Completed by Healthcare Provider—Please only provide results from October 1, 2016 through December 31, 2017, and use “Preventive” or “Annual Wellness” billing codes.**

☐ Fasting  ☐ Non-fasting  ☐ Patient is Pregnant

Date of Screening: (DD/MM/YYYY)

Total Cholesterol (TC): [ ] mg/dL

Body Mass Index: [ ] kg/m²

Height (in inches): [ ] in.

Weight (in pounds): [ ] lbs.

TC/HDL Ratio: [ ]

Glucose: [ ] mg/dL

Completion of Annual Exam: [ ]

Date of Annual Exam: (DD/MM/YYYY)

Blood Pressure: [ ]/ [ ] mm Hg

Healthcare Provider’s Name (Please Print): __________________________

Phone: __________________________

Office Address: __________________________

City/State/Zip: __________________________

Healthcare Provider’s Signature: __________________________

Date: (DD/MM/YYYY)

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If you have an office stamp, please apply here:

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Do not submit this request form to your Human Resources department. All information provided is kept strictly confidential, is protected by law, and is not disclosed to your employer. Results provided do not preclude eligibility in any benefit program.

© 2017 Provant - The “standards-based” wellness program administered by Provant complies with applicable provisions of the Health Insurance Portability and Accountability Act (HIPAA) and the Affordable Care Act including 29 CFR 2590.702, et seq. and 45 CFR 146.121, et seq.

17-CAR-HSR2