State Health Benefits Program
Retiree Wellness Program
Annual Wellness Certification

Please Print

Name: ____

Date of Birth (MM/DD/YYYY): _________________________

NJ DIRECT Member ID # HZN__________________________

Phone Number: _______________________________________

Have you participated in an annual physical examination with your participating physician? Yes __ No __

If yes, please indicate the date of the visit and physician's name and phone number:

____

List all health screenings recommended by your physician and completed during the current plan year along with the date of completion:

Health Screening / Date: ____

Health Screening / Date: ____

Health Screening / Date: ____

I certify that the information provided above is correct and authorize any provider who participated in care and treatment to release all medical or other information requested by Horizon Blue Cross Blue Shield of New Jersey in conjunction with the Retiree Wellness Program. This information is for the sole use of the State of New Jersey and Horizon BCBSNJ to administer the Retiree Wellness Program.

Member Signature / Date: ____

Physician Name (Please Print) / Date: ____

Physician Signature / Date: ____

We will advise the SHBP that you have completed the annual physical exam with health screenings. Your individual results will not be reported to the SHBP.

Fraud Warning: *Any person who knowingly files a statement containing false or misleading information is subject to criminal and civil penalties.*

26889(0209)

Physician Certification

Please have your physician complete and sign the “Annual Wellness Certification” form on the other side of this page. Mail to:

Horizon Blue Cross Blue Shield of New Jersey
State Health Benefits Program – Retiree Wellness Program
Three Penn Plaza East PP – 03G
Newark, New Jersey 07105-2200