Wellness Program

Verification Form | Due 12/31/2026

Four Seasons
Family of Companies

This form is used to verify completion of an annual wellness exam or lab work.

PLEASE NOTE: Inform your Provider that your appointment and any lab work ordered are for routine preventive care and are to be processed as **preventive care**. This helps ensure that you are not billed for these services.

Patient information (Associate or Spouse):

First Name: _____ Last Name: _____

Gender: ◯ Male ◯ Female

Category: ◯ Associate ◯ Spouse (Associate's Name: _____)

I understand that participation in this program is voluntary. I authorize my Healthcare Provider to release the requested information necessary to verify my participation in my employer's voluntary wellness program.

Signature: _____ Date: _____

To be completed by provider:

The patient named above is under my care and:

◯ **Wellness Exam -** has completed an annual wellness exam on (date): _____
(This exam may include an annual physical, mammogram, OB/GYN, colonoscopy, or prostate exam)

◯ **Biometric or Lab Work -** has completed annual preventive lab work on (date):_____

Provider Name: _____

Provider Address: _____

Provider Signature: _____ Date: _____

Scan the QR code or click the link to upload this completed form to receive credit towards the 2026 Wellness Program.