2025 Routine Physical Exam Certification Form

Eligibility Requirement

Bryten Team Members who become eligible for benefits after 01/01/2025 are eligible to earn a Wellness Premium Discount to their current medical plan premiums by obtaining and certifying that they have had a recent annual physical examination with a health care provider.

This certification form can be completed and signed by a health care provider and submitted to Bryten Benefits Team to receive the Wellness Premium Discount of $30.00 per month. **Wellness Discount will take effect first of the month following receipt of this form, there will be no retro payment.** Alternatively, a copy of dated receipt of service will also serve as eligibility for discount.

Employee Responsibility

Use this form to certify that you have had a recent routine physical examination or obtain a copy of dated receipt of service and send with form.

Bryten Team Members are responsible for submitting the completed certification form or receipt to the Benefits Team.

Form Submittal Instructions:

1. Team Member completes Part I, Employee Information
2. Health Care Provider completes Part II, Health Care Provider Verification or attach receipt of service
3. Submit forms to: benefits@livebryten.com

PART I - EMPLOYEE INFORMATION

Name: _____ Hire Date _____

Employee Certification – I certify that I have obtained a routine physical exam from a healthcare provider.
Wellness Discount will take effective first of the month following receipt of this form, there will be no retro payment.

_____ Date_____
Team Member's Signature

Responses are subject to audit. Any misrepresentation or misstatement of the responses may terminate your eligibility, render invalid all benefits under the plan and require repayment of any benefit received pursuant to such misrepresentation or misstatement.

PART II – HEALTH CARE PROVIDER VERIFICATION (To be completed by health care provider)

Name of Healthcare Provider: _____ Date _____

Office Address: _____

Date of Exam/Screening _____ _____
*Office Stamp Here

_____ Date _____
Health Care Provider or Representative Signature

Print Name _____

*Should your health care provider not have an Office Stamp, a note on a prescription pad or letterhead or copy of receipt will suffice.

Date received in HR: _____ Effective Date: _____Approved by: _____Paycom_____

Revised 4/1/2025