Premium Reward Review Form

July 1, 2016- June 30, 2017

Benefits Administrator: If you have an employee who is not receiving a premium reward (as confirmed using the PSBREW function for employee and/or spouse) and can provide documentation to support a reward, complete this form in full on behalf of the participant and submit to ohb@dhrm.virginia.gov or fax to 804-371-0231. **You must include *a copy of the PSBREW screen shot and* documentation* to support the reward along with this request.**

Please allow 6-8 weeks from the date the premium reward requirements have been submitted and accepted before you request a review using this form.

Participant's BES ID number:_____

Participant's Name:_____

Participating spouse name (if applicable):_____

Agency Name:_____ Contact's Name:_____
Agency Phone Number:_____ Agency E-mail:_____
Date:_____

Request review for premium reward period beginning:_____

Health Assessment: Date completed: _____

Documentation: A certification of completion of the health assessment from MyActiveHealth.com/COVA portal

Biometric Screening : Indicate Date Physician form was submitted: _____

*Documentation: ***Confirmation from WellAdvantage showing acceptance of the physician screening form.***

Indicate any pertinent information:

_____

_____

For OHB use:

07/2016