Southern California Conference
of Seventh-day Adventists
(818) 546-8415; Fax (818) 546-8475

2019 SCC HCAP PHYSICAL EXAM INCENTIVE APPLICATION

Participant's name: _____ **Employee's name, if different:** _____

IF EMPLOYED AT AN ACADEMY, WHERE: _____

The Southern California Conference of Seventh-day Adventists will reward a 2019 SCC Blue Shield participant with $100.00, up to a maximum of $200.00 per family. This benefit **is taxable** and will be paid through your payroll check with the required withholdings. To ensure proper handling and processing of the incentive, please send this completed application, with supporting documentation to:

Southern California Conference of SDA
Human Resources Department
P.O. Box 969
Glendale, CA 91209-0969

FAX: (818) 546-8475
e-mail: DdeAsis@sccsda.org

Please read and initial ☐

I am a participant in the SCC Blue Shield Health Care Plan and apply for the physical examination incentive. I understand that the maximum I can be reimbursed is $100.00 with a $200.00 family maximum. Each participant applying for a reimbursement must complete a separate application. **One** of the following is required, therefore I am including:

1. My health care provider's completed certification at the bottom of this form; **OR**
2. A note on letterhead from my health care provider certifying that I had a comprehensive physical examination and which specifies the date of the exam in the plan year January 1 - December 31, 2019; **OR**
3. An itemized statement or receipt from my health care provider showing that I had a physical examination in the plan year of January 1 – December 31, 2019.

Participant's address _____

_____

Participant's signature _____

CERTIFICATION TO BE COMPLETED BY PHYSICIAN OR OSTEOPATH:

I am a physician or osteopath duly licensed to practice medicine in the United States. I certify that I performed a comprehensive physical examination on the above named patient. I have used my reasonable medical judgment in selecting the tests and procedures performed and have discussed the results with the patient.

The exam was completed_____(date).

_____
Printed name of provider

_____ _____
Signature of health care provider Date signed

For SCC HR Department use only: Incentive amount approved: $ _____ _____ _____
Initials Date