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

2020 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 2020 SCC United Healthcare 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 United Healthcare 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, 2020; **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