

**CERTIFICATION OF PREVENTATIVE CARE – 2024 BENEFIT YEAR**Complete the following three steps and earn: **$50 per month premium discount for employee medical coverage. $50 per month for employee’s *covered* spouse.**

1. Bring this form to your preventive health care visit.
2. Ask your provider to complete the bottom red area of the form.
3. Turn in your completed form by mailing it to “Benefits, 8820 American Way, Englewood CO 80112” or email it to benefits@afwonline.com.

\*Annual effective date of discount will be the date the form is submitted to benefits. The discount will be applied from the MONDAY immediately after your form is received by benefits. Your discount will expire after one year from the date of your preventive visit.

You will need to resubmit this form to receive the discount when you get your next preventative care exam.

**Employee Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employee Number: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Spouse’s Name if certification is for your spouse:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TO BE COMPLETED BY THE MEDICAL PROVIDER:**

**Please verify below that I have received some type of age and gender specific preventive health care by signing below. Please do not indicate what type of preventive health care I received or provide the results of any routine tests.**

|  |  |
| --- | --- |
| Complete One Preventive Care Item: | Date Completed: |
| * Annual Physical
 |  |
| * Mammogram
 |  |
| * Colonoscopy
 |  |
| * Other
 |  |

|  |  |  |
| --- | --- | --- |
| Provider Name |  |   |
| Street Address |  |   |
| City, ST, ZIP Code |  |   |
| Phone |  |   |
| Provider Signature |  |   |