SALTCHUK
FAMILY OF COMPANIES

Annual Preventive Exam Verification Form

To support the health and well-being of our employees and their families, the Saltchuk Family of Companies rewards members who engage in healthy behaviors. To receive a discount on your medical premiums in 2026, you and your covered spouse or domestic partner must get a preventive exam in 2025.

Use this form as proof of completion of your annual exam if it was completed this year prior to you joining our organization, or if you had a physical required by a federal agency during the year (e.g., DOT, Coast Guard, etc.).

Section I: Participant Information

(To be completed by participant)

Full Name (Please print clearly): _____

Date of Birth (MM/DD/YYYY): _____ Last 4 of SSN: _____ Check One: ☐ Employee ☐ Spouse

Email Address (Please print clearly): _____

Annual Preventive Exam Verification Method (Select one):

☐ I will have my provider fill and sign Section II of this form

☐ I will submit visit documentation in lieu of Section II of this form.
Options for acceptable visit documentation include an Explanation of Benefits (EOB) or a visit summary that clearly shows patient name, date of service, and service(s) performed. One of these types of visit documentation must be submitted with this form. ***Sign below, gather documentation, then skip to Section III.***

Attestation: I certify that the information included on this form is accurate to my knowledge. I understand that (1) my data will be shared with the administrator of the wellness program, but my individual results will NOT be shared with my employer, and (2) it is solely my responsibility to follow up with my personal physician if I have questions or concerns regarding my health.

Participant Signature: _____ Date: _____

Section II: Service and Provider Information

(*Have your provider fill and sign Section II* ***OR*** *attach and submit your visit documentation)*

Exam Information

Person Receiving Exam: _____ Date of Exam: _____

Exam Performed: ☐ Annual Adult Wellness Exam ☐ Exempt - Not Medically Necessary
☐ Physical required by a federal agency (e.g., CDL, DOT, Coast Guard, etc.)

Provider Information

I hereby certify that the above named person received an annual preventive exam on the date noted above.

Provider Name (Please print clearly): _____

Provider Signature: _____ Date: _____

Practice Name and Address: _____

Section III: Form Submission Instructions

This form and all related documentation (if applicable) must be submitted by the program deadline in order to receive credit for completing your annual preventive exam.

Submit your completed form via secure file upload by clicking here or scanning the QR code, or email your completed form to GBS.SaltchukWellness@ajg.com.