2025 Dodge County Wellness Program

Annual Physical & Biometric Affidavit Form

Employees and their spouses, if covered by the Dodge County Insurance Plan, must complete an annual physical **plus** a biometric screening to receive lower premium rates for the 2026 plan year. To qualify for the 2026 lower premium rate, employees must complete the physicals and biometric screening between 11/1/24 – 10/31/25. However, if you received your physical 10/1/2023-10/31/2023 and then again have a physical in October of 2024, the October 2024 physical will count toward your 2026 requirement.

Please Complete:

Employee Printed Name: _____

Patient Printed Name: _____

Patient is (please circle): Employee OR Spouse

Plan Participant Attestation (Both Part A and B to be Completed)

Part A: Annual Preventative Care Visit

☐ I hereby certify that I have completed an Annual Preventive Care Visit with my physician.

Physician Certification

I do hereby certify that the above-named plan participant has completed an Annual Preventive Care Visit on: _____.

(Date of Annual Preventive Care Visit)

Physician Printed Name: _____

Physician Signature: _____ Date: _____

Part B: Biometrics Screening

☐ I hereby certify that I have completed an onsite biometric screening through Dean at the County.

Note: If you complete your biometric screening onsite at the County via Dean Health Plan, then no physician signature is needed below.

OR

☐ I hereby certify that I have completed an appropriate age and gender biometric screening at the time of my annual preventive care visit with my physician.

Physician Certification

I do hereby certify that the above-named plan participant has completed an Annual Preventive Care Visit on (date of annual preventive care visit): _____.

Physician Printed Name: _____

Physician Signature: _____ Date: _____

*I understand that this document must be completed by both my provider and me and **returned to HR** by **October 31, 2025**, to receive the discounted premium for the 2026 plan year. I do hereby attest that the above information is true and correct to the best of my knowledge. I further acknowledge and understand that if I knowingly and willfully make a false or fraudulent statement, I may lose the ability to retain the wellness contribution rate for my health coverage in the future.*

Participant Signature: _____ Date: _____

RETURN TO HUMAN RESOURCES – hr@co.dodge.wi.us