Fischer Homes Wellness Program Affidavit

Please review this affidavit carefully
Sign and date at the bottom and return it to the Wellness Team at
Wellness@fischerhomes.com

Associate/Spouse Information:

Name:

Department:

Primary Care Physician (PCP) Information:

Name:

Clinic/Practice Name:

Affidavit:

I, hereby affirm that I visited my primary care physician, for my annual physical examination on . This visit was part of my participation in the Fischer Homes Wellness Program for the year 2025.

Authorization to Release Protected Health Information to my Employer:

I understand that by submitting this form, Fischer Homes Wellness Program will apply a discount to the Associates medical insurance premium. No other personal information will be shared.

By signing this affidavit, I certify that the information provided above is accurate. I understand that any misrepresentation in the information I provided above may result in disciplinary action up to and including termination of employment. I authorize the release of the information noted above.

Associate/Spouse Signature:

[Associate/Spouse Full Name] [Date]

*If you are the spouse of the Fischer Home Associate, please provide the Associate's full name below.

If you have any questions regarding your benefits or wellness program options, contact the wellness team at wellness@fischerhomes.com or call 859 – 344 – 4887.