PROOF OF PHYSICAL FORM FOR 2027 BENEFIT YEAR
DEADLINE: DECEMBER 15, 2026

This form must be completed and signed by the participant and physician and received and accepted by the Fund Office ***by December 15 of each year*** *for it to be processed in time for the participant to be included in the Wellness Tier coverage on the following January 1.*

Dear Doctor or Health Care Provider,

The I.B.E.W Local No. 38 Health and Welfare Fund has coverage tiers designed to encourage participants to get annual physical exams. I am voluntarily participating in this program. I am required to provide verification that I executed an annual physical examination. Please send the completed form to the I.B.E.W Local No. 38 Health and Welfare Fund as indicated below.

SECTION 1. TO BE COMPLETED BY THE PARTICIPANT
By signing this form, you agree to voluntarily authorize the physician to verify your physical examination in order to qualify for Wellness Tier coverage.

DATE: _____

DATE OF BIRTH: _____

PARTICIPANT'S NAME: _____

PARTICIPANT'S SIGNATURE: _____

SECTION 2. TO BE COMPLETED BY THE EXAMINING PHYSICIAN
By signing this form, you acknowledge that you completed an annual physical examination of the Fund participant.

DATE OF THE PHYSICAL EXAM: _____

EXAMINING PHYSICIAN'S NAME: _____

EXAMINING PHYSICIAN'S OFFICE ADDRESS: _____

_____

EXAMINING PHYSICIAN'S OFFICE PHONE NUMBER: _____

EXAMINING PHYSICIAN'S SIGNATURE: _____

DATE: _____

RETURN THIS COMPLETED FORM BY MAIL, FAX OR EMAIL TO:
I.B.E.W Local No. 38 Fringe Benefits
P.O. Box 6326
Cleveland, OH 44101-1326
Fax: 216-431-7719
Email: tammy@ibew38-benefits.com