

**LORAIN COUNTY COMMUNITY COLLEGE
PREVENTIVE CARE VERIFICATION FORM FOR SPOUSE
LEVEL I HEALTH CARE INCENTIVE**

Spouse's/Patient's name: _____
(Type or print legibly)

LCCC Employee's name: _____
(Type or print legibly)

Dear Doctor:

My spouse's employer, Lorain County Community College, will provide him/her with a discount on his/her medical insurance premiums, if on an annual basis he/she completes an online health risk assessment and receives some type of age and/or gender specific preventive health care. He/she will receive an additional discount if I meet the same standards.

(Please note that the medical insurance coverage described below is applicable only if the spouse/patient has coverage under the college's medical plans. If he/she has coverage through his/her own employer, it may be different. It is the spouse's/patient's responsibility to verify his/her insurance coverage for preventive care.)

Below for your reference is a list of tests for which the college's medical plans will provide **100% coverage**, if ordered as **routine/preventive care** and not in association with a medical diagnostic code. You may order any one or more of the following tests you deem appropriate, in order for me to be considered as having received some type of preventive health care:

EKG	Metabolic Panel	PSA Test
CBC	Urinalysis	Pap Test
Lipid Profile	Fecal Occult Blood Test	Mammogram
Fasting Glucose		CA 125 Test

The college's medical plans also provide coverage (80% - 100% coverage depending on which of the college's medical plans I am enrolled in) for a routine colonoscopy at age 50 and every 5 years thereafter.

Please verify below that I have received some type of age and/or gender specific preventive health care during the current calendar year, by signing below. Do not indicate what type of preventive health care I received or provide the results of any routine tests that have been performed, as the college does not need or want access to that information. Thank you.

_____ has received preventive health care during _____
Spouse/patient **Year**

_____ _____ _____
Physician's Name (Please print) **Physician's Signature** **Date**

Please return this form to me and I in turn will forward it to the college. Thank you.

LEVEL II HEALTH CARE INCENTIVE

Lorain County Community College will also provide my spouse with an additional premium discount if I sign an affidavit stating that I have not used tobacco products in the last 90 days and if I have three of the five factors, which contribute to Metabolic Syndrome, under control. (Under control can also mean doing so with the assistance of medication.) Those five factors, along with their recommended standards are listed below:

- Waist circumference $\leq 35''$ for women and $\leq 40''$ for men
- Triglycerides (level of blood fat) ≤ 150 mg/dL
- HDL (good cholesterol) ≥ 50 mg/dL for women and ≥ 40 mg/dL for men
- Blood pressure $\leq 120/80$
- Fasting Glucose (blood sugar) ≤ 110 mg/dL

Please verify whether or not I have at least three of the five factors which contribute to Metabolic Syndrome under control, by signing below. Do not indicate what my biometric measurements are or which factors I have or have not met, as the college does not want or need access to that information. Thank you.

Spouse/Patient

(Please check the applicable answer below.)

- _____ Has at least three of the five factors listed above under control.
- _____ Has less than three of the five factors listed above under control. (He/she does not have a medical condition which would prevent him/her from meeting the standards.)
- _____ Has less than three of the five factors listed above under control. (However, he/she has a medical condition that would make it unreasonably difficult or medically inadvisable for him/her to meet the standards* at this time.)

Physician Name (Please print)

Physician Signature

Date

**The metabolic syndrome standard will be waived for those spouses, whose doctors have indicated that it would be medically inadvisable for them to meet it.*

Tobacco Free Affidavit:

I am certifying that I have been tobacco-free for 90 consecutive days as of this date.
(Date) _____

Spouse's Printed Name

Spouse's Signature

