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## Consent for Deductible Waiver under the Wellness Program

By signing below, you acknowledge that you are not accepting the Gift Card during the Wellness Year period of 1/1/23 – 12/31/23 and instead are choosing to have your deductible waived under the Health Plan for the Calendar Year 2024. Please note that if married, both the member and spouse must agree and sign to have their deductible waived rather than accept the gift card.

Please check:

Member:

Spouse:

Member SSN: \_\_\_\_\_

\_\_\_\_\_  
Member's Name (Print)

\_\_\_\_\_  
Member's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Spouse's Name (Print)

\_\_\_\_\_  
Spouse's Signature

\_\_\_\_\_  
Date

This form **MUST** be returned to the Health Fund for processing.

Your Options:

Email it to: [wclaims@benesys.com](mailto:wclaims@benesys.com)

Fax to: 608-846-3224

Mail to: WI Laborers Health Fund, 4633 Liuna Way, Suite 201, Deforest WI 53532