2020 Enrollment Form

Name:		**Date of Birth:**
Department:		
Street Address:		**City:**
State:	**Zip Code:**	**Phone#:**
Email:		

Will you enroll in a City of El Centro health plan for 2020? YES NO

Please complete the following section if your spouse would like to participate in the wellness program:

Spouse Name:	**Date of Birth:**
Phone#:	**Email:**

Enrollment Instructions:

1. Each participant must complete this enrollment form.
2. The Human Resources Department will contact you to schedule an appointment for a biometric screening.
3. Complete the biometric screening.
4. Once you receive the results, complete the Personal Health Profile at https://wellness-connect.net
5. Review the Wellness Points Guide and begin participating in activities.
6. Get healthy, lose weight, improve your physical condition, feel better!

Agreement and Waiver:

The undersigned participant agrees that participation in the City of El Centro Employee Wellness program shall be undertaken at his/her sole risk and that the City of El Centro shall not be liable for any injuries, accidents or deaths occurring to the participant, arising either directly or indirectly out of participating in the City of El Centro Employee Wellness program. The participant, for him/herself and on behalf of his/her executors, administrators, heirs and assigns, does hereby expressly release, discharge, waive, relinquish, and covenants not to sue the City of El Centro, its officers and agents for all such claims, demands, injuries, damages or cause of action, with respect to participation in the Employee Wellness program. The undersigned participant agrees to abide by the policies of the City of El Centro Employee Wellness program.

Additionally, by signing this form the undersigned participant authorizes the City of El Centro to deduct the $10 fee for the employee portion of the biometric screening ($40 if you miss your appointment), $7 for the PSA test (if applicable) and $40 for enrolled spouse from his/her paycheck.

Signature of Employee: _____ Date:_____

Signature of Spouse (if enrolled):_____ Date:_____