# Wise and Well Completion Form (2020 Update)

**INSTRUCTIONS:** Fill out the information below and return to NMRHCA (front and back).

**PLEASE PROVIDE PROOF** of completion or ongoing participation in program (certificate of participation, receipt, attendance record, letter from doctor/program leader); forms without proper documentation WILL BE REJECTED.

Please complete two separate programs for credit. Examples of classes and resources are available at nmrhca.org/wellness-incentive.aspx. *If you complete a personal health assessment or health risk assessment, we suggest that your second activity be based on your assessment results.

Also, note that screenings (such as blood pressure or cholesterol readings), lab work and/or flu shots or other immunizations DO NOT QUALIFY as a wellness activity. If you engage in an in-person personal health assessment with your physician or registered nurse, there must be a discussion and action plan about wellness, which can include (such as a nutrition/diet plan, physical activity, managing a chronic illness through non-medicinal means, balance or falls prevention techniques, etc.).

---

I have completed or am active in the following wellness programs/courses that I wish to apply toward credit for a $50 Gift Card. I understand that NMRHCA may verify and must approve both selections to qualify for credit. *** Please note that you are allowed to turn in one form per calendar year. ***

Your name: _____ Date: _____

**First Wellness Program:**

_____

_____

**Second Wellness Program:**

_____

_____

**(PLEASE COMPLETE THE BACK SIDE OF THIS PAGE)**

---

FOR OFFICIAL USE ONLY

NMRHCA Verification: _____

# Wise and Well Completion Form — Pg. 2

**Program Type (check one)**

- ☐ Fitness/Exercise
- ☐ Diabetes Management/Prevention
- ☐ Chronic Disease Management/Prevention
- ☐ Nutrition/Weight Management
- ☐ Health/Wellness Education/Smoking Cessation
- ☐ *Personal Health Assessment/Health Risk Assessment → →

**Program Type (check one)**

- ☐ Fitness/Exercise
- ☐ Diabetes Management/Prevention
- ☐ Chronic Disease Management/Prevention
- ☐ Nutrition/Weight Management
- ☐ Health/Wellness Education/Smoking Cessation
- ☐ PHA/HRA Action Plan

*(For a list of program ideas/options, visit NMRHCA.org/wellness-incentive.aspx)*

**Your Health Plan (please circle one):** BCBS Humana Presbyterian UnitedHealthcare

Has your address changed in the last 12 months?
If yes, please provide a current address:

_____

_____

Please provide a current email so we can confirm successful completion of program

Email: _____

Phone: _____

Date of Birth: _____

**Please return this form to New Mexico Retiree Health Care Authority. You may also mail it to us at: 6300 Jefferson St., NE, Suite 150, Albuquerque, NM 87109 or email it to us at NMRHCA.wellness@state.nm.us.**

*If you have any questions, please contact us at 1-800-233-2576 or email us at NMRHCA.wellness@state.nm.us*

---

**DISCLAIMER: Only members and their spouses participating in medical plans are eligible to receive the gift card.**

- **Dependent children are not eligible.**
- **Members who have VOLUNTARY COVERAGE ONLY (Dental, vision or life insurance) without medical coverage are not eligible.**
- **Please allow 6-8 weeks from the end of the month in which you submitted your form for delivery.**