



Aviva Life and Annuity Company
 800/800-9882
 P.O. Box 1555
 Des Moines, IA 50306-1555

Wellness For Life Program Rewards Qualification Form

COMPLETE ALL SECTIONS (Please print or type all information except signatures. Please use black ink.)

The **Wellness for Life Program** is a life insurance policy benefit established to encourage and reward healthy living. In order to qualify for potential wellness rewards, participating insureds must get a routine physical exam once every two years and manage his/her weight within a range established by the insurance company at policy issue. The purpose of this form is to provide the insurance company with a verified record of the insured's routine physical and notation of weight.

Instructions for Insured: Complete this form and have it signed by your doctor/health care provider at your regularly scheduled routine physical. Return this form to the address of the company you checked above.

Notice to Insured: The Company will share the status of qualification for Wellness Rewards with the policy owner. In the event the insured is not the policy owner, submission of this form provides authorization to the Company to share Wellness qualification status with the policy owner.

Name of Insured:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date: ____/____/____ (mm / dd / yyyy)
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Insured's Social Security Number: ____ - ____ - _____ Policy Number: _____

Insured's Address: _____

City: _____ State: _____ Zip Code: _____

Insured's Height: ____ ft. ____ in. Insured's Weight: _____ lbs. **Attention Home Office:** If extenuating circumstances are listed below, code the weight as "9999".

Please indicate if the insured has any special physical conditions (e.g. pregnancy, body cast, etc.) or if there currently are extenuating circumstances that substantially affect the insured's measured weight.

Date of routine physical when above measurements were taken: ____/____/____ (mm / dd / yyyy)

Name of Doctor / Health Care Provider: _____

Address of Doctor / Health Care Provider: _____

Signature of Doctor / Health Care Provider: _____

Date: ____/____/____ (mm / dd / yyyy)

Note: All costs associated with any physical exams undergone to meet the **Wellness for Life Program** qualification criteria are the responsibility of the insured and/or policy owner.

