



MUS WellWeight Program Contract

Please answer each question below. Partially completed contracts will be returned.

Today's date: _____

1. Name: _____ Date of birth: _____

2. Contact telephone number: _____ email: _____

3. Mailing address: _____

4. Are you on the MUS Medical Benefits plan? Yes ___ No ___

5. You must be on a managed care plan to participate. Which plan are you on?

Allegiance ___ BCBS ___ New West ___ Peak ___

6. Policy holder's full name as it appears on the insurance card: _____

7. Have you read through all of the WellWeight Program information? Yes ___ No ___

8. How long have you been overweight/obese? _____

9. Have you tried weight loss programs/diets before? Yes ___ No ___

Which ones, for how long, any success (add additional info on reverse of contract if needed)?

10. On a scale of 1-10, 1 being not ready and 10 being ready now, where are you to begin a serious weight loss program? _____

11. For some people, there is an event that triggers them to take action in a weight loss course of action. Did you have an event or why do you want to enroll in this program?

12. Do you understand the Program requirements and that any non-compliance with the program guidelines and requirements can result in termination from this program? Yes ___ No ___

13. Do you agree to the three evaluations during and after program completion? Yes ___ No ___

14. Please designate an advocate/friend/family you can talk with for support during this program.

Name _____ Phone and email: _____

This is a voluntary program. I understand this is an 18 month, once in a lifetime benefit, and I must be on the MUS medical benefit plan to qualify. Expenses that occur prior to approval or after one year will not be reimbursed. This benefit may be terminated if I do not comply with the program requirements. By signing this form, I agree to program management coordination for qualifying expenses. I may revoke this authorization at any time. I agree to be contacted to provide more information following program completion for program evaluation purposes. I understand all my personal information will be kept confidential.

Signature _____ date: _____

Please mail or fax this form to: MUS Benefits (Att: WellWeight) 406-444-0222, 2500 Broadway, Helena, MT 59601.

Upon receipt of this contract, you will be contacted within 14 business days.