

**FAX Cover Sheet**

*You must include your certificate from Impact Solutions*

**Attached required documentation must include your name and date of completion.**

**Date:** \_\_\_\_\_ **Number of Pages (including cover):** \_\_\_\_\_

**Your Name** (please print): \_\_\_\_\_

**Are you the subscriber for Miami's health plan (health premium deducted from *your* paycheck)?**

**YES.** Enter your MU uniqueID: \_\_\_\_\_

(This is your Miami uniqueID, for example, employjn)

**NO.** Enter your MU uniqueID: \_\_\_\_\_

(This is your spouse's MU uniqueID followed by "\_sps", for example employjn\_sps)

**Your MU uniqueID can be found in your Healthy Miami account under "My Profile."**

**Birth date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Your email:** \_\_\_\_\_

**Your phone:** (\_\_\_\_) \_\_\_\_\_

This information is considered confidential and will be used only for the Premium Discount Program (PDP) to qualify you (and/or your spouse) for a reduction to your health premium.

The submitted coaching documentation will complete the PDP requirement for the current plan year only. If you are not tobacco-free at the beginning of the new plan year, you will need to complete the tobacco cessation program again, as the completion of the tobacco-free certification is required annually.

**Submit to TriHealth: Fax to 513-852-7491 or email to [MiamiScreenings@trihealth.com](mailto:MiamiScreenings@trihealth.com)**

Please keep a copy of this form for your records.