Following is a template for developing a waiver for reasonable alternative standards within your organization. This is not a legal document – just a template for consideration. Please consult your legal counsel prior to fully executing a reasonable alternative waiver at your organization.

Dear Healthcare Provider,

As personal healthcare provider (PCP) for a *(Insert Company Name)* employee or their spouse, we would like to make you aware of an opportunity for us to work collaboratively to support him or her in achieving good health. *(Insert Company Name)* employees and spouses who achieve the *(Insert the name of the wellness program)* targets can save up to *($$$)* on their health plan contributions. Those who don't meet the targets initially can earn the full value of the annual premium reduction by achieving the targets or reasonable alternatives by year-end. he *(Insert Plan Year)* targets are:

- Target One
- Target Two
- Additional Targets

Occasionally, it may be appropriate to modify the *(Insert the name of the wellness program)* targets. Certain health conditions may make it unreasonably difficult to satisfy, or medically inadvisable to attempt to satisfy, the targets. In such circumstances, *(Insert the name of the wellness program)* will consider providing individuals with reasonable alternatives to qualify for the premium reductions, or if medically necessary, waivers for the *(Insert the name of the wellness program)* program requirements. For Example: (Consider providing examples here)

Providers: For *(Company Name)* *(Insert the name of the wellness program)* to grant a reasonable alternative or medical waiver due to a serious health condition or pregnancy, please indicate the targets affected, health condition and expected duration.

_____

_____

Provider name *(please print)*: _____ *Phone:* _____

Provider signature: _____ *Date:* _____

Employee/spouse name *(please print)*: _____ *Employee #:* _____

Employee/spouse signature: _____ *Date:* _____
(Signature acknowledges compliance with an individual care plan outlined by PCP)

Please call (Name) at (Phone Number) with any questions. Thank you for your support of *(Company Name)* *(Insert the name of the wellness program)*

Best regards,

**Fax completed forms to (Name) at (Fax Number) within 30 days of hire or benefits eligibility.*