



Maricopa County Employee Wellness Program StayWell Consent Form

Please **print** your name as it appears on your badge. All information asked below is necessary for consent.

First Name _____ Last Name _____

Home Street Address _____

City _____ State _____ Zip _____

Employee ID Number 81 _____ Date of Birth ___/___/___ Gender: M or F _____

Authorization for Maricopa County to Release Information to StayWell

In order to qualify for wellness incentives, such as medical premium reductions, and participate in certain Maricopa County wellness programs, information about you will need to be exchanged between Maricopa County and its wellness services administrator, StayWell ("StayWell").

By signing this consent, I authorize Maricopa County to send the following information about me to StayWell in order to accomplish the purpose of administering biometric and tobacco screenings, health assessments, and wellness related programs and benefits: employee name, address, gender, date of birth, employee I.D. number, and information necessary to verify my eligibility for wellness incentives. I understand such information will be kept confidential as between Maricopa County and StayWell.

My consent will remain effective from the time I submit this document through such time that I am no longer enrolled in a County-sponsored medical plan, unless I revoke it in writing and deliver my consent revocation to the Employee Benefits Division.

Signature _____ Date _____

Complete all the information above, sign and date this form, and email it to:
BenefitsService@mail.maricopa.gov