



2017 CHS LiveWELL Incentive Financial Health Alternative Form

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REQUIRED: Employee ID#
(Find six-digit ID# by your name on paycheck)

Last Name (print legibly)

First Name

Middle Initial

Birth date: ___ mo/___ day/___ year **Best phone to reach you:** _____

Work Location & Department _____

I am enrolled in the following CHS LiveWELL Health Plan (circle one): **Yes** **No**

Instructions: Ask your financial advisor or educator to complete the information below.

Financial Health Alternative

(To be completed by your financial advisor or educator)

I am the financial advisor for this teammate

This teammate completed a financial education program

Date(s) of program/advising: _____

Today's Date: ___ mo/___ day/___ year

Advisor's/Educator's Name (**printed**): _____

Advisor's/Educator's Signature: _____

Phone Number: _____ Business or Educational facility name: _____

Deadline: This form must be received by CHS LiveWELL no later than
November 6, 2017

Fax the completed form before the deadline to CHS LiveWELL at **704.446.1635** or email to
CHSLiveWELLRewards@CarolinasHealthCare.org.
Retain your completed copy of this form and your fax confirmation until your incentive reward is received.