VERIFICATION FORM FOR THE 2026 USW/CLEVELAND-CLIFFS HEALTH AWARENESS INITIATIVE

INSTRUCTIONS:

-Separate forms are required for each employee/retiree and spouse, if applicable.
-Employees/retirees or spouses: Fill out Section 1
-Healthcare provider: Fill out Section 2
-Successful completion of the 2026 Health Awareness Initiative by you and your spouse, if applicable, qualifies you for HRA funding in 2027.

IN ORDER TO MEET THE 2026 HEALTH AWARENESS INITIATIVE REQUIREMENT:

(1) It is mandatory that the employee/retiree and spouse, if applicable, each submit this completed form, and
(2) The Wellness Examination must be completed between **10/01/2025 - 12/31/2026** if you did not already complete the HAI requirement prior to the original 9/30/2026 deadline, and
(3) This completed form must be submitted by 1/15/2027

SUBMIT FORMS BY EMAIL OR MAIL:

Email: **ccliffshai@gmail.com** (you will receive an email confirmation once your form has been received and reviewed) Mail: Steelworkers Health and Welfare Fund, 60 Blvd of the Allies, Suite 700 - Pittsburgh, PA 15222

SECTION 1

Patient Information: ***(TO BE COMPLETED BY EMPLOYEE, RETIREE OR SPOUSE - PLEASE FILL OUT ALL ITEMS IN THIS SECTION)***

Check One: ☐ ***I AM AN ACTIVE EMPLOYEE, RETIREE, OR SURVIVING SPOUSE***
☐ ***I AM THE SPOUSE OF AN EMPLOYEE OR RETIREE AND AM COVERED UNDER THEIR CLEVELAND-CLIFFS HEALTHCARE PLAN***

Last Name:	First Name:	MI:

Home Address:	City:	State:	Zip:

Email Address:

Date of Birth:	Phone:	Status of Employee: ☐ **Active Employee** ☐ **Non-Medicare Retiree or Surviving Spouse**

Insurance Card ID# *(NUMERIC PORTION ONLY)*:

SIGNATURE: ***DATE:***

SECTION 2

Healthcare Provider: ***(TO BE COMPLETED BY PROVIDER - DO NOT PROVIDE EXAMINATION RESULTS)***

The above named patient was seen in my office on the date of service listed below. I completed the examinations of height, weight, blood pressure, and a discussion of appropriate recommended exams, screenings and procedures. ***Provider is not liable if patient does not follow recommendations.***

Date of Service:	

Provider Name:	Provider Phone:

PROVIDER SIGNATURE: ***DATE:***

***ATTENTION PROVIDER:**
Work physicals: A Work Physical does not qualify as a wellness exam.
Preventive testing: When ordering preventive testing for your patient, please refer to the Highmark BCBS Preventative Schedule for covered testing when tests are ordered and coded as preventive/screening. Tests not included within this schedule will not be covered without a diagnosis code other than "routine", and patient could be responsible for the entire charge. Tests ordered and coded for diagnostic purposes will be processed under the diagnostic benefit, and medical policy guidelines will be used in determining benefit and payment.

Form revised 09/30/2026