Archdiocese of St. Louis

Employee Wellness Form

Benefit-eligible employees who wish to participate in the Archdiocese's Wellness Program and earn the **Wellness Incentive Retirement Contribution (WIRC)** are encouraged to complete their free, confidential H&H Wellness Screening at an on-site event or any approved H&H walk-in clinic during the 2027 fiscal year. Employees who are unable to participate through H&H may instead complete a Wellness Exam with their personal physician.

To be eligible for the WIRC, employees must have at least one year of service and either work a minimum of 1,000 hours annually or be a teacher with a half-time or greater contract.

Eligible employees who complete either the free, confidential H&H Wellness Screening or a Wellness Exam through their personal physician *(co-pays or other charges may apply)* between **July 1, 2026, and June 30, 2027**, and who meet all participation and reporting requirements, will receive a **$125 contribution to their Archdiocese of St. Louis-sponsored 403(b) retirement plan**.

Participation at an approved H&H walk-in clinic requires pre-registration through H&H (call 800-832-8302, M-F, 8:30am-5pm). There is no cost for the once-per-year H&H Wellness Screening, no appointment is required, and same-day service is available. No additional reporting is required by employees who participate through H&H.

Employees participating through their personal physician must submit this completed form to H&H Health Associates by June 30, 2027, via email at nurses@hhhealthassociates.com or by fax to 314-845-8087.

For additional information, please review the **Wellness Screening FAQ** available on the **Employee Wellness Programs** website.

Employee Instructions: Please fill out all requested information.

Employee Last Name (please print): First Name: Employee ID: Date of Birth: (mm/dd/yy)

Home Street Address: Phone #

City: State: Zip Code:

Name of Parish, School, or Agency Employer: Your Email Address (optional):

CERTIFICATION: I certify that I received an annual wellness exam with my physician on the date noted below. I understand that if I provide false information, it may lead to disciplinary action.

Your Physician's Name: (Physician is not required to sign this form) **Date of Physician Exam:**

Employee Signature: **Date:**

Employee Instructions: This completed and signed Employee Wellness Form should be sent to H&H Health Associates. Email is the recommended method of delivery so that you have proof of sending the form.

Questions, please view the Wellness FAQ on the Employee Wellness Programs Default Site or direct emails to AskHR@archstl.org	**Fax:** H&H Health Associates 314.845.8087 Attn: Nurses	**Email:** H&H Health Associates at nurses@hhhealthassociates.com Subject: Physician Waiver