Bank of America 2027 U.S. Wellness Activities

Healthcare Provider Medical Waiver Form

Member ID
#

Dear Healthcare Provider,

Participants in the Bank's group health plans can choose to complete three wellness activities (a health risk assessment, a health screening, and an attestation showing that they have a primary care provider (PCP) and have had an annual physical with their PCP in the last 12 months) in order to keep an annual wellness credit that offsets annual medical plan premiums. The health risk assessment is a questionnaire available online that consists of questions related to the participant's health and lifestyle. The health screening consists of the following: blood pressure measurement, BMI, weight, waist circumference, total cholesterol (non-fasting), and A1C. The attestation that they have a PCP and have had an annual physical with their PCP in the last 12 months is available online.

However, if a participant is pregnant or it's medically inadvisable or unreasonably difficult for them to participate in one or more of the three wellness activities based on a medical condition, they may submit this Healthcare Provider Medical Waiver Form in lieu of completing one or more of the wellness activities.

If, due to a medical condition, it is medically inadvisable or unreasonably difficult for the individual named below to participate in the health risk assessment, health screening or PCP and annual physical attestation, **please complete this affidavit and the participant will receive a waiver for all requirements**. For example, pregnant women do not need to participate in the health screening to retain the wellness credit. Another example would be someone who was incapacitated due to a medical issue and unable to complete the health risk assessment and/or health screening during the completion timeline.

Please review this waiver carefully, attest to the appropriate information, and then sign and date the form at the bottom. The participant must also sign and date the form and return the completed form before their wellness activity window deadline date. Please ensure all fields are completed and retain a copy of this form for your records.

The information provided on this form will be kept confidential and will not be used for any purpose other than to determine if the participant is eligible for a waiver of the health risk assessment, health screening and/or PCP/annual physical attestation.

Completed by Participant:

Participant First Name (Print) **(Required)** _____ Last Name **(Required)** _____

Participant Date of Birth (MM/DD/YY) _____

Consent to Use Information: I, Participant, hereby authorize my provider to release any information within this form to my wellness program, Well Dot, Inc. I understand that Well Dot, Inc. will utilize this information solely for the purposes of administration of its wellness program and will dispose of this form in accordance with any applicable law.

Participant's Signature: _____ Date: _____

Completed by Healthcare Provider:

As the participant's treating healthcare provider, I hereby attest that it is medically inadvisable or unreasonably difficult due to a medical condition for the participant above to complete the following wellness activities (**please check any that apply**):

☐ Complete a health risk assessment ☐ Complete a health screening ☐ PCP/Annual physical attestation

Health Care Provider Name: _____ Date: _____

Health Care Provider's Signature: _____

Submission instructions:

Take a picture and upload it via chat to a Well Guide on mywellnessbofa.com or the Well Digital mobile app.

You may also **email a copy of this form to** bofa.mywellness@support.well.co or reach out to a Well Guide for mailing instructions.

If you have questions about the waiver process, please contact Well Member Services at **bofa.mywellness@support.well.co** or by calling 844.939.5100. Representatives are available Monday through Friday from 8 am to 9 pm ET.