



**EMPLOYER BASED WELLNESS PROGRAM
YEAR-END PROGRAM/ACTIVITY CONFIRMATION**
NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 58437 (01-2014)

**NDPERS • PO Box 1657 • Bismarck • North Dakota 58502-1657
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Complete this form, front and back, answering every question as completely as possible, use an extra sheet of paper if additional space is needed. Incomplete forms will be returned.

PART A EMPLOYER INFORMATION	
Organization	NDPERS Organization Id
Wellness Coordinator	
E-Mail	Telephone number
PART B MANDATORY REQUIREMENTS	
<p>Affirmative answers to the following questions are mandatory. Verify that each mandatory item below was met during the plan year. Please affirm by initialing each box.</p> <p><input type="checkbox"/> Wellness Commitment Agreement SFN 58643 signed by top management?</p> <p><input type="checkbox"/> Wellness Coordinator assigned to agency/group?</p> <p><input type="checkbox"/> Someone from the agency/group attended or viewed the NDPERS Wellness Forum?</p>	
PART C MANDATORY FIVE (5) POINT SYSTEM	
<p>Five (5) points are required to qualify for the wellness discount. Verify completion of points based on program activities. Please affirm by initialing each box and describe program activities on the backside of this form.</p> <p><input type="checkbox"/> Did you communicate wellness materials provided by NDPERS/BCBS to individual employees on a monthly basis and if a state agency, university or district health unit, promote the NDPERS smoking cessation program to employees. (1 Point)</p> <p><input type="checkbox"/> Did you complete a wellness activity/program #1 as indicated on your Employer Based Wellness Program Discount Application SFN 58436? Describe in Part D, Section A. (2 Points)</p> <p><input type="checkbox"/> Did you complete a different wellness activity/program #2 as indicated on your Employer Based Wellness Program Discount Application SFN 58436? Describe in Part D, Section B. (2 Points)</p> <p><input type="checkbox"/> Did you complete a comprehensive wellness program? Describe in Part D, Section C. (Must have prior approval from NDPERS.) (4 Points)</p> <p style="text-align: right;">TOTAL <input type="text"/></p>	



PART D WELLNESS ACTIVITY DESCRIPTION

Section A. Short-Term Wellness Activity/Program 1:

Percentage of Employees that Participated: _____ %

Describe the wellness activity/program you offered, methods for promotion, and your evaluation of the activity:

	YES	NO
Was this the activity/program you indicated you would do on your discount application?	<input type="checkbox"/>	<input type="checkbox"/>
Was the activity/program completed?	<input type="checkbox"/>	<input type="checkbox"/>
Would you recommend this activity/program to another employer or offer it again?	<input type="checkbox"/>	<input type="checkbox"/>
If "NO", please indicate why: _____		

Section B. Short-Term Wellness Activity/Program 2:

Percentage of Employees that Participated: _____ %

Describe the wellness activity/program you offered, methods for promotion, and your evaluation of the activity:

	YES	NO
Was this the activity/program you indicated you would do on your discount application?	<input type="checkbox"/>	<input type="checkbox"/>
Was the activity/program completed?	<input type="checkbox"/>	<input type="checkbox"/>
Would you recommend this activity/program to another employer or offer it again?	<input type="checkbox"/>	<input type="checkbox"/>
If "NO", please indicate why: _____		

Section C. NDPERS Approved Comprehensive Wellness Program:

Percentage of Employees that Participated: _____ %

Describe the wellness program you offered, methods for promotion, and your evaluation of the activity:

	YES	NO
Was this the activity/program you indicated you would do on your discount application?	<input type="checkbox"/>	<input type="checkbox"/>
Was the activity/program completed?	<input type="checkbox"/>	<input type="checkbox"/>
Would you recommend this activity/program to another employer or offer it again?	<input type="checkbox"/>	<input type="checkbox"/>
If "NO", please indicate why: _____		

PART E WELLNESS COORDINATOR APPROVAL

Wellness Coordinator Signature:

Date: