



UID _____

**Preventive Care Incentive Program Participation Form 2020
For (Pace University) Medical Plan Participants**

Please complete/sign the authorization below:

Employee Name: _____

Patient Name (if different): _____

Please include the date that the preventive screening was performed:

Preventive Screening	Date Performed
Annual Routine Physical Exam	

I attest that the information that I have provided on this form is true and accurate.

Signature of Employee: _____ Date: _____

The annual routine physical examination must be completed by December 31, 2020.

In order to be awarded **1** raffle entry:

1. Complete and sign this form.
2. Include only the first page of the corresponding Explanation of Benefits (EOB) document.
3. Submit to the University Benefits office at PCare@pace.edu, which will create a Help Desk ticket, by **Friday, January 15, 2021**.