



2025 Wellness Rewards Program

Orion Steel Group LLC encourages employees to lead a healthy and active lifestyle, and as such you have an opportunity to earn **\$300** in the 2025 calendar year. To receive your reward you must complete these steps by October 31st:

1

Get your annual preventive care exam.

This is covered at no cost through your medical insurance.

2

Get your annual biometric screening.

This includes a full lipid profile with cholesterol, blood sugar and blood pressure.

3

Have your provider complete the attached form.

Provide the completed form to Portland Human Resources as instructed.

Deadlines

Payment will be made in December 2025.

Note: You must be an active employee at the time of payment (partial or early payments will not be provided). You will not be eligible for the credit if the bloodwork (biometrics) completed does not include ALL of the following: Total Cholesterol, HDL, LDL, Triglycerides, and Glucose.

TO BE COMPLETED BY PARTICIPANT:

Participant Name: _____

Participant Address: _____

Participant Date of Birth: _____

Participant Email: _____

By signing and submitting this form I agree that I am currently a Portland employee enrolled in the Kaiser Medical plan. I agree to present this completed form to my local Human Resources department by October 31, 2025 to be eligible for an annual wellness credit of \$300.00 on my final paycheck in December. I understand that it is my responsibility to: 1) ensure that test results are omitted from this form 2) direct questions regarding testing to those administering the tests and 3) follow up with my physician to discuss the results of these tests. **Test results are considered private and confidential health information that should not be shared with the company's Human Resources.**

Participant Signature

TO BE COMPLETED BY MEDICAL PROVIDER ONLY:

I hereby attest that the above-named participant (patient) received the following services (please check all that apply):

☐ Preventive health exam, performed on _____
(date)

☐ Bloodwork, performed on _____ which includes (please check all that apply):
(date)

- ☐ Total cholesterol
- ☐ HDL
- ☐ LDL
- ☐ Triglycerides
- ☐ Glucose
- ☐ Fasting 9-12 hours
- ☐ Blood pressure

Facility Name _____

Facility Phone Required _____

Printed Name of Medical Provider _____

NPI Number _____

MEDICAL PROVIDER SIGNATURE _____

*Today's Date ____ / ____ / ____

Please provide completed form to the participant.

Form must be received by Portland Human Resources by 10-31-2025.