TEAMSTERS LOCAL 727 HEALTH & WELFARE FUND

Healthy Living & Wellness Program - 2025

Section 1: Patient Information

Patient Name: First Last

Date of Birth: / / ☐ Male ☐ Female

Patient Phone: / - ☐ Member ☐ Spouse

E-mail:

Member ID *(FUN)*: Last Four SSN:

Section 2: To be completed by Physician (Exam and Labs must be completed between 1/1/2025 -12/31/2025

Date of Exam: / / Fasting? ☐ Yes ☐ No

Blood Pressure: Systolic Diastolic Weight (Pounds): Height (Inches):

Cholesterol: Total: HDL: LDL:

Triglycerides: Glucose:

Preventative Screening *(Physician to determine if screenings medically necessary)*

	Yes Completed	No Not Completed	N/A Not Needed
Digital Prostate Exam:	☐	☐	☐
Mammogram:	☐	☐	☐
Pap Smear:	☐	☐	☐
Hemoccult Colon Screening:	☐	☐	☐

Physician Name: First Last

Physician Phone: / -

Physician Signature Date

All information is required. Completed form must be submitted by 04/01/2026. Please submit to:

Mail: Elite Administration & Insurance Group, Inc.
1300 W. Higgins Road, Suite 208 | Park Ridge, IL
Park Ridge, IL 60068

Fascimile: 312/243-8678

Email: CustomerService@eliteadmin.com

2025