UFCW LOCAL 1776 AND PARTICIPATING EMPLOYERS HEALTH AND WELFARE FUND

Biometric Screening Form – 2026 Benefits

Submission Deadline: 60 days after enrollment

Biometric screening data and lab work must have been collected within 60 days of enrollment and returned to the Fund Office immediately thereafter. Biometric Screening Forms are only required if you wish to enroll in the best medical plan available to you. If you have a spouse who is covered under your benefit plan, he/she must also complete a Form. Please print all information clearly.

Please return to the fund office within 60 days of enrollment using the following contact information:
Mail: 3031 B Walton Road Plymouth Meeting PA, 19462 | **Email:** fund@1776funds.org | **Fax:** (610) 941-9602

Patient Information (All Info Required)

Full Name:		Phone Number:
Gender:	Date of Birth:	Last Four Digits of SS#:
E-mail:	Employer:	
Please check one:	☐ I am a participant in the UFCW Local 1776 and Participating Employers Health & Welfare Fund ☐ I am the spouse of a participant	

Spouse's Information (If Applicable)

Spouse's Full Name:	Last Four Digits of Spouse's SS#:
Is your spouse a participant of the UFCW Local 1776 and Participating Employers Health & Welfare Fund? ☐ Yes ☐ No	

Biometric Screening Data and Lab Work (All Info Required)

To be filled out by a physician within 60 days of enrollment.

Biometric Screening Data
Date of Collection:
Height (Feet and Inches):
Weight (Pounds):
Blood Pressure (Systolic):
Blood Pressure (Diastolic):

Lab Work	
Date of Collection:	
Total Cholesterol HDL:	
Cholesterol:	
LDL Cholestrol:	
Triglycerides:	
Glucose: (and/or) A1C:	
Is the patient currently fasting? ☐ Yes ☐ No	

Preventative Screenings (Not Required)

Has the patient completed the screenings below within the recommended timeframe?	Yes	No	N/A
Pap Smear (Within the last 3 years for women age 21 or older)			
Mammogram (within the last 1-2 years for women age 40 or older)			
Prostate Cancer Screening (for men age 45 or older with family history)			
Colorectal Screening (Men over 45)			
Fecal Occult Blood Test			
Colonoscopy			
Does the patient smoke/chew/use tobacco products?			

Physician's Name: _____ **Physician's Phone:** _____

Physician's Signature: _____ **Date:** _____

Questions? Call the Fund Office at 610-941-9400