## **Community DPP Participation Form**

Employees and spouses enrolled in a medical plan sponsored by the State Personnel Department can receive up to \$100 for participating in a community Diabetes Prevention Program.

Please note, it can take up to <u>four weeks</u> for this form to be processed. Your form is considered processed when the ActiveHealth Rewards Center shows the activity as complete.

Your reward must be visible in the ActiveHealth Rewards center by 12/31/25.

## **Form Submission Instructions**

This form should only be used if you are participating in a community Diabetes Prevention Program. You are able to submit this form at each milestone, or when all milestones are completed.

How to submit the completed form:

- Login to your ActiveHealth Portal <u>www.myactivehealth.com/stateofindiana</u>
- Click on the Rewards Icon and then the tile for Participate in a Diabetes Prevention Program (DPP).
- Follow the instructions to upload the form.
- You will receive a message stating "Upload Successful". You may print this for your records.
- After allowing for the four week processing time, login to your ActiveHealth Portal to see your reward.

SECTION 1 - TO BE COMPLETED BY THE PARTICIPANT – ALL FIELDS ARE REQUIRED NO REWARD WILL BE PROVIDED FOR PARTIAL OR INCOMPLETE FORMS Enter information as it appears on your health insurance card.		
Participant First Name: Participant Date of Birth (Month/Day/Year):		
Participant Last Name: Gender: Female Male		
Participant Email:		
	$\Box$	
Participant Zip Code: Participant Phone Number:		
Name of Indiana State Employee (leave blank if Participant is the Employee):		
	$\Box$	
I certify I have attended the session/sessions below. I authorize the release of my attendance records in order to receive the reward.		
rticipant Signature:		

SECTION 2 – Complete the information below for e information and signature is required for each mile	each Diabetes Prevention Program milestone. Facilitator estone to earn the reward.
Milestone 1: 1 <sup>st</sup> DPP Session Attended	
Date:	
Facilitator Name:	Phone Number:
Facilitator Signature:	
Milestone 2: 4 <sup>th</sup> DPP Session Attended	
Date:	
Facilitator Name:	Phone Number:
Facilitator Signature:	
Milestone 3: 8th DPP Session Attended	
Date:	
Facilitator Name:	Phone Number:
Facilitator Signature:	
Milestone 4: 5% Weight Loss Achieved	
Date:	
Facilitator Name:	Phone Number:
Facilitator Signature:	

## Check your form for these common errors

- $\Box$  Make sure your milestone dates are in 2025.
- $\hfill\square$  Include your name as it appears on your insurance card in clear print.
- □ Make sure your DPP facilitator signs each milestone and facilitator contact number is provided.