



# POINTS SUBMISSION FORM

PLAN YEAR: \_\_\_\_\_

<input type="checkbox"/> PREVENTION <input type="checkbox"/> HEALTHY LIVING <input type="checkbox"/> EDUCATION <input type="checkbox"/> PHYSICAL <input type="checkbox"/> OTHER: _____	<input type="checkbox"/> PREVENTION <input type="checkbox"/> HEALTHY LIVING <input type="checkbox"/> EDUCATION <input type="checkbox"/> PHYSICAL <input type="checkbox"/> OTHER: _____	<input type="checkbox"/> PREVENTION <input type="checkbox"/> HEALTHY LIVING <input type="checkbox"/> EDUCATION <input type="checkbox"/> PHYSICAL <input type="checkbox"/> OTHER: _____	<input type="checkbox"/> PREVENTION <input type="checkbox"/> HEALTHY LIVING <input type="checkbox"/> EDUCATION <input type="checkbox"/> PHYSICAL <input type="checkbox"/> OTHER: _____	<input type="checkbox"/> PREVENTION <input type="checkbox"/> HEALTHY LIVING <input type="checkbox"/> EDUCATION <input type="checkbox"/> PHYSICAL <input type="checkbox"/> OTHER: _____
<input type="checkbox"/> ACTIVITY: _____ <input type="checkbox"/> COMPLETED DATE: _____ POINTS EARNED: _____				
<input type="checkbox"/> ACTIVITY: _____ <input type="checkbox"/> COMPLETED DATE: _____ POINTS EARNED: _____				
<input type="checkbox"/> ACTIVITY: _____ <input type="checkbox"/> COMPLETED DATE: _____ POINTS EARNED: _____				

**EMPLOYEE NAME:**

\_\_\_\_\_

Printed

\_\_\_\_\_

Signature

\_\_\_\_\_

Submission Date

\_\_\_\_\_

Date Received by HR