**Preventive Care Surcharge Accommodation**
**June 1, 2026 – May 31, 2027 Plan Year**

*(To be completed by the colleague's and/or spouse/partner's treating physician)*

Dear Physician,

As a health care company that cares about the health and wellbeing of our colleagues, CVS Health has a preventive care surcharge for its medical coverage that supports our focus on health and wellbeing and that is intended to encourage our colleagues to obtain routine adult preventive care.

In order to avoid the surcharge, the colleague and their spouse/partner (if enrolled in a CVS Health Aetna medical plan) must obtain proof that an adult preventive visit (e.g., annual physical, annual well-woman exam) occurred for each plan year.

Alternatively, the colleague and/or spouse/partner, as applicable, may provide this completed Preventive Care Surcharge Accommodation to avoid the surcharge. A new completed Preventive Care Surcharge Accommodation is required for each plan year.

Please review this attestation carefully and then sign and date this form. The information that you provide on this form will be kept confidential and will not be used for any purpose other than to determine whether the surcharge will apply.

Physician Attestation:

As the treating physician of _____(*insert name of patient*), I attest that such person is currently under my care for treatment of a complex or specific health condition or disability and it is unreasonably difficult due to a medical condition, or medically inadvisable, for such person to obtain an adult preventive visit at this time, or such person's disability prevents them from obtaining an adult preventive visit at this time.

Physician Name _____
Physician Signature _____
Physician Tax ID Number _____
Date _____

By signing below, I certify that this form was submitted to my physician or my spouse's/partner's physician, who is identified above and who provided the attestation shown above.

Colleague Name _____
Colleague ID Number_____
Spouse/Partner Name (if applicable) _____
Colleague Signature _____
Spouse/Partner Signature (if applicable) _____
Date _____

**How to submit this documentation:**
Please email the completed form to CVSHealthBenefits@CVSHealth.com