Wesleyan University Incentive Points Program  
Faculty, Staff, Spouses & Partners not enrolled in the Wesleyan Cigna plan

Account Summary for ________________ (enter Time Period)

Name_________________________________________________________________ Wesleyan ID________________

If you need more than six entries, you may attach copies of this page and complete and sign them.

Milestone______________________________________  Date completed________________________________
Activity name___________________________________  Description_____________________________________
Points earned__________

Milestone______________________________________  Date completed________________________________
Activity name___________________________________  Description_____________________________________
Points earned__________

Milestone______________________________________  Date completed________________________________
Activity name___________________________________  Description_____________________________________
Points earned__________

Milestone______________________________________  Date completed________________________________
Activity name___________________________________  Description_____________________________________
Points earned__________

Milestone______________________________________  Date completed________________________________
Activity name___________________________________  Description_____________________________________
Points earned__________

Milestone______________________________________  Date completed________________________________
Activity name___________________________________  Description_____________________________________
Points earned__________

Milestone______________________________________  Date completed________________________________
Activity name___________________________________  Description_____________________________________
Points earned__________

To the best of my knowledge, the information I have entered above is correct. I understand that if I provide false information I may be subject to corrective action.

Signature_______________________________________ Date______________________

Send this completed form to the Benefits Office in the early January or early July.