HealthPlans, Inc.

Fitness Reimbursement Form

Did you know that you can submit your claims reimbursement request online? Just log in to My Plan at HealthPlansInc.com.

Employer Name: ______________________________ **Group Number:** ____________

WHAT TYPES OF HEALTH CLUBS QUALIFY UNDER THIS BENEFIT?

- Qualified, full-service health and fitness facilities that provide cardiovascular and strength-training equipment and facilities for exercising and improving physical fitness qualify, such as health clubs and fitness centers, YMCAs and YWCAs, Jewish Community Centers and municipal fitness centers.
- Fitness studios/facilities that offer the following activities also qualify: yoga, Pilates, Zumba®, aerobic/group classes, indoor cycling/spinning classes, kickboxing, CrossFit®, strength training, tennis, indoor rock climbing, personal training *(taught by a certified instructor)*.
- The following do not qualify for reimbursement: fees for group classes or personal training outside of a fitness facility/studio; health club initiation fees; costs for instructional dance studios, country clubs, social clubs (*e.g.*, skiing, riding or hiking clubs), spas, gymnastics facilities, martial arts schools, pool-only facilities, road race fees, sport camps, ski passes, sports teams/leagues and school sports athletic user fees.

WHEN TO SUBMIT THIS FORM:

- Please refer to your Plan Document or your Summary of Benefits and Coverage for specific details concerning this benefit, including limits and/or restrictions, under your plan.
- Once all sections have been completely filled out and signed by the employee, please mail the completed form with all necessary documentation (copies of receipts and your health club membership agreement form) to Health Plans.

Employee Information

Employee Last Name	*First Name*	*MI*	*Health Plans Member ID#*

Mailing Address	*City*	*ST*	*ZIP Code*

Date of Birth	*Email Address*	*Primary Phone*

Member/Dependent Information

Reimbursement is requested for the following participant *(please check)*:

☐ Employee ☐ Spouse/Partner ☐ Child/Other Dependent ☐ Ex-Spouse

If reimbursement is requested for a participant *other than the employee*, please provide the dependent information below:

Last Name	*First Name*	*MI*	*Gender*	*Date of Birth*	*Relationship*

Health Club Information

Please provide the following information:

DATES ATTENDED: From: MM/DD/YYYY To: MM/DD/YYYY	FITNESS CLUB NAME	ADDRESS, CITY & STATE	PHONE NUMBER *(incl. Area Code)*	$ AMOUNT CLAIMED
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I certify that the information on the form and all supporting documents are complete, accurate and unaltered.

Signature: ______________________________ ____________________

Signature of Employee *Date Signed*

Submit this completed form and your supporting documentation to:

Health Plans, Inc. — Corporate Headquarters • PO Box 5199 • Westborough, MA 01581 • 800-532-7575 • 508-792-1188 *(fax)*

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