SOUTHCOAST HEALTH SYSTEM

Health Plan

FITNESS REIMBURSEMENT FORM

Southcoast Health Plan

Group Number: 001SHP

WHAT TYPES OF HEALTH CLUBS/PROGRAMS QUALIFY UNDER THIS BENEFIT?

- A qualified, full-service health and fitness club with cardiovascular and strength-training equipment and facilities for exercising and improving physical fitness.
- **New for 2014: Yoga instruction classes.**
- Examples of facilities/programs that DO NOT qualify for reimbursement include: Martial arts centers, gymnastic facilities, classes (other than qualified yoga instruction classes), country clubs, fees for personal trainers, tennis, aerobic or pool-only facilities, as well as sports teams and leagues.

WHEN TO SUBMIT THIS FORM:

- After you have been a member of a health club or completed four qualified yoga classes and have been covered under the Southcoast Health Plan for at least four consecutive months.
- As expenses are incurred or by March 31st of the following year, with proof of payment and health club or yoga program information (copy of health club membership agreement or yoga program enrollment documentation).
- Once all sections have been completely filled out and signed by the employee, please mail completed form with all necessary documentation (copies of receipts and health club membership agreement or yoga program enrollment documentation) to:

Health Plans, Inc., PO Box 5199, Westborough, MA 01581

* ***Please note: Maximum amount reimbursable is $150 per family per calendar year.***

To Be Completed by Employee

Employee Last Name	*First Name*	*MI*	*SCHP Member ID #*	*Date of Birth*

Mailing Address	*City*	*ST*	*ZIP Code*	*Home Phone*	*Email Address*

Member/Dependent Information

Reimbursement is requested for the following participant *(please check)*: ☐ **Employee** ☐ **Spouse** ☐ **Child**

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 / Yoga Program Information

List the health club/program that you are claiming for reimbursement and the qualifying four consecutive months of membership/participation.

DATES ATTENDED: From: *MM/DD/YYYY* To: *MM/DD/YYYY*	*FITNESS CLUB NAME OR YOGA INSTRUCTOR/FACILITY*	*ADDRESS, CITY & STATE*	*PHONE NUMBER (including 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 the completed form, copy of your health club membership agreement, and receipts to:

Health Plans, Inc., P.O. Box 5199, Westborough, MA 01581