SOUTHCOAST HEALTH SYSTEM
Health Plan

FITNESS REIMBURSEMENT FORM

Southcoast Health Plan

Group Number: 001SHP

WHAT TYPES OF HEALTH CLUBS 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.
- Examples of facilities/programs that DO NOT qualify for reimbursement include: Martial arts centers, gymnastic facilities, 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 and 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 information (copy of health club membership agreement).
- 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) 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 Information

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

DATES ATTENDED: *From: MM/DD/YYYY To: MM/DD/YYYY*	*FITNESS CLUB NAME*	*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

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