

Fitness Reimbursement Form

Please read the instructions below, then proceed to fill out the Fitness Reimbursement Form.

Mailing Instructions

1. Please enclose a copy of your health club membership agreement.
2. Please enclose proof of health club membership payment (cash/check receipts or credit card receipts) — must equal or exceed amount being claimed.
3. Mail completed information and required documentation to:

Harvard Pilgrim Health Care
P. O. Box 9185
Quincy, MA 02269

Important information about submitting your reimbursement form:

- Definition of a qualified, full-service health and fitness club: a facility with cardiovascular and strength-training equipment and facilities for exercising and improving physical fitness.
- Facilities/programs that **DO NOT** qualify for reimbursement include: Martial arts centers, gymnastics facilities, country clubs, fees for personal trainers, tennis, aerobic or pool-only facilities, as well as sports teams and leagues.
- Keep copies of all documentation before sending in your fitness reimbursement form.
- You must mail the form and all supporting documents together (in the same envelope).
- Incomplete forms will not be processed.
- Reimbursement checks will be mailed and made payable to the Subscriber only at the Subscriber's address of record. No alternative address will be accepted.
- If you believe your current address is different than the address of record in Harvard Pilgrim's systems, please contact us prior to submitting your Fitness Reimbursement Form. In most cases we will update your address in our systems directly — in other cases, when your employer submits transactions to us electronically, we will ask you to inform your employer of your address change.
- Please allow 6-8 weeks for processing.

Standard reimbursement requirements:

1. Subscriber's employer must offer Harvard Pilgrim's fitness reimbursement program.
2. Reimbursement is up to \$150 per calendar year in total for health club membership dues for subscriber and/or their dependents.
3. Reimbursement is for monthly or annual membership dues only.
4. Subscriber must be active, i.e., a current member of Harvard Pilgrim, at the time of Harvard Pilgrim's receipt of a complete fitness reimbursement form.
5. Current Harvard Pilgrim membership must be equal to or greater than four consecutive months in length with the same employer group in a calendar year.
6. Health club membership must be for at least four consecutive months in length in a calendar year.
7. Proof of payment of the health club membership dues must be provided with the fitness reimbursement form. (Cash/check/credit card receipts are acceptable)
8. A copy of your fitness health club membership agreement must be provided with the fitness reimbursement form.
9. Subscriber may receive fitness reimbursement **only** once for a calendar year.

Questions

Please call 1-888-333-4742 with any questions about reimbursement requirements and/or how to submit this form. For TTY service, call 1-800-637-8257.

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*This information refers to plans offered by Harvard Pilgrim Health Care and its affiliates, including Harvard Pilgrim Health Care of New England and HPHC Insurance Company.
Fitness reimbursement program requirements are subject to change without notice.*

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Fitness Reimbursement Form

To be filled out by Harvard Pilgrim Health Care SUBSCRIBER only. Please use blue or black ink and print all information clearly.

When to submit this form:

- After your employer has added the fitness reimbursement program.
- After you have been a member of a health club and Harvard Pilgrim Health Care for at least four consecutive months in a calendar year.
- Once per calendar year, filed by March 31 of the following year, with all necessary receipts and health club contract.
- Once all sections have been completely filled out and signed by the subscriber.

Section A – Subscriber Information (person who holds coverage)

Harvard Pilgrim ID Number	Subscriber's Last Name	First Name	Middle Initial
Date of Birth (mm/dd/yyyy)	Social Security Number (at least last four digits)		
Address		City	State ZIP Code
Daytime Phone (area code) xxx-xxxx		Company Name (Employer)	

Section B – Subscriber and/or Member Information for Reimbursement

Harvard Pilgrim ID Number	Last Name	First Name	Date of Birth (mm/dd/yyyy)
Harvard Pilgrim ID Number	Last Name	First Name	Date of Birth (mm/dd/yyyy)
Harvard Pilgrim ID Number	Last Name	First Name	Date of Birth (mm/dd/yyyy)

Section C – Health Club Information (list all health clubs that you and/or your dependent(s) are submitting for reimbursement listing the qualifying four consecutive months.)

ATTACH DOCUMENTATION	Calendar Year	Club Name	City, State	Phone Number (Area Code) xxx-xxxx	\$ Amount being claimed
	From: mm/dd/yyyy To: mm/dd/yyyy				
	From: ___ / ___ / _____ To: ___ / ___ / _____				
	From: ___ / ___ / _____ To: ___ / ___ / _____				
	From: ___ / ___ / _____ To: ___ / ___ / _____				

Total number of documents _____

Total dollar amount being claimed \$ _____
up to \$150 per calendar year

I certify that the information on the form and all supporting documents are complete, accurate and unaltered.

Subscriber's Signature _____

Date _____