FITNESS PROGRAM REIMBURSEMENT FORM

Benefit eligible employees may request reimbursement for a fitness facility membership and/or a combination of fitness classes. Minimum utilization required for reimbursement is 30 visits (limited to one visit per day). Refer to the Health Benefits Guide/SPD for program details.

Employee Name: _____ Department: _____

I hereby request reimbursement under the Fitness Program for the following reimbursement period:

☐ January – June -- **Deadline: July 15** ☐ July – December -- **Deadline: January 15**

I understand that I must submit this completed form along with the following:

- **Detailed receipt(s) for requested reimbursement period**
  Ancillary services such as food/beverages, tanning, massages, childcare, etc., are not reimbursable. The Program will only reimburse the amount that was paid for a membership minus any ancillary services, i.e., base membership. If detailed services, membership cost and membership period are not clearly identified on receipts, membership contracts and/or facility pricing may be requested for clarification prior to reimbursement. The Plan reserves reimbursement rights. The amount reimbursed shall not exceed the amount paid to the facility/program for the specified period.
- **Printed member utilization**
  Facility computer-generated report or Member Utilization Tracker with facility stamp/initials: Limited to one visit per day.
- **Signature of the facility's authorized representative**

I understand that reimbursement is not available for membership fees prior to my insurance effective date. I also acknowledge that any reimbursement from this program will be reported as a taxable fringe benefit. I understand that this completed form and required attachments must be submitted by the deadline noted above.

Employee Signature: _____ Date: _____

Return completed form to the Commissioners' Office or email wellness@woodcountyohio.gov. **Late submissions will not be accepted.**

FOR FACILITY/PROGRAM USE ONLY

I certify that the following individuals participated in the fitness facility/program listed below.

Provide a copy of each member's utilization to identify the dates the member(s) utilized the facility.

Facility/Program Name _____

List Member Name(s) _____

Authorized Representative Name _____ Phone _____

Authorized Representative Signature _____ Date _____

FOR ADMINISTRATIVE USE ONLY - Do not write below this line

☐ This request is being returned to you ineligible due to the following: ☐ No signature by member/facility
You have until _____ to resubmit for reimbursement. ☐ No contract/receipt/utilization

☐ Request not eligible for reimbursement due to: ☐ Did not meet 30 visits ☐ Received after deadline
☐ Member not eligible

☐ Request eligible for reimbursement as noted:

Name (Family contract is limited to 3 people)	Visits	Eligible Reimbursement Amount
		$
		$
		$
Total Amount Eligible for Reimbursement		$
Total Paid during Reimbursement Period		$
TOTAL REIMBURSEMENT (Max $450/family not to exceed Total Paid during Reimbursement Period		$

Initials _____ Date _____

MEMBER **UTILIZATION TRA**CKER

This form can be used if electronic reporting is not available.

Member Name: _____

One Member per form please.

Facility Name: _____

Membership Period ☐ January – June ☐ July - December

Members are responsible to ensure that utilization is properly reported. Members must meet the minimum 30 visit utilization requirement and complete all other program requirements to qualify for reimbursement. Members wishing to obtain a higher reimbursement must meet the 60 visit utilization requirement.

Facility: please stamp, sign/initial and date for each member visit

1	2	3	4	5	6
7	8	9	10	11	12
13	14	15	16	17	18
19	20	21	22	23	24
25	26	27	28	29	30
31	32	33	34	35	36
37	38	39	40	41	42
43	44	45	46	47	48
49	50	51	52	53	54
55	56	57	58	59	60