UFCW LOCAL 1776 AND PARTICIPATING EMPLOYERS
HEALTH AND WELFARE FUND

Physical Well-Being Benefit Direct Reimbursement Form

Check the applicable areas for which you are requesting reimbursement:

☐ Fitness Center ☐ Smoke Cessation ☐ Weight Loss ☐ Golf Club ☐ Swim Club ☐ Martial Arts ☐ Other

PARTICIPANT INFORMATION & CERTIFICATION *(Participant completes this section)*

Participant Name: **Dependent Using Facility/Program:**

Participant Address:

Participant Social Security No. (*last 4 digits*): XXX-XX-

Participant Employer Name & Store No.: **Full-time/Part-Time?:**

Participant Phone No.:

PARTICIPANT CERTIFICATION *(All participants must sign and date below):*

I hereby certify that the foregoing information is true and correct to the best of my knowledge, information and belief. I further certify that I am subject to punishment for making false statements under 18 PA C.S.A 4904.

PARTICIPANT'S SIGNATURE: DATE:

FACILITY/PROVIDER INFORMATION & CERTIFICATION *(Provider completes this section)*

Facility/Provider Name:

Facility/Provider Tax ID No.:

Facility/Provider Address:

Facility/Provider Phone No.:

Membership/Course Fee:

Individual/Family Membership?: **Date Membership Purchased?:**

PROVIDER CERTIFICATION *(Facilities/providers must complete and sign and date below):*

***For fitness centers, golf club, swim club, and martial arts centers*:**

I certify that _____ has used the above named facility _____times from _____ to _____.
Name of Participant # days/#sessions Begin Date End Date

***For smoking cessation, weight loss, and other programs*:**

I certify that _____ has completed a _____course/program from _____ to _____.
Name of Participant Name of course/program Begin Date End Date

PROGRAM DIRECTOR'S SIGNATURE: DATE:

INSTRUCTIONS ON HOW TO COMPLETE THIS FORM

1. This Reimbursement Form must be completed by the participant and by the provider.

2. Attach the following information to the Reimbursement Form:
   a. A legible copy of the Provider Agreement (contract with the gym or other facility) between you and the facility, if applicable;
   b. Legible copies of itemized receipt(s) and proof of payment (Check, Visa statement, etc.)

3. Return the completed Reimbursement Form, along with a copy of the Provider Agreement (if applicable) and itemized receipt(s) and proof of payment to the Fund Office at:

UFCW Local 1776 and Participating Employers Health and Welfare Fund
3031 B Walton Road
Plymouth Meeting, PA 19462

NOTE: If you sign up for an annual membership (i.e. gym membership), both you and the facility must complete a Reimbursement Form, and submit it, along with the verification information, to the Fund Office twice each membership year (i.e., if your membership year is from January through December, you must submit a Reimbursement form by June 30th and by December 31st).

If you join a program that is not utilized throughout the entire year (i.e. smoke cessation, weight loss, swim clubs, other eligible program expenses, etc.), both you and the facility and/or provider must complete the Reimbursement Form, and submit it, along with the verification information, to the Fund Office upon completion of the program.

To request a Reimbursement Form, please call the Fund Office at 1-610-941-9400 or toll free at 1-800-458-8618.

Claims must be filed no later than 90 days from the end of the calendar year in which the membership or participation in a program or other eligible program expense occurred.