HNE Weight Watchers® and Fitness Reimbursement Form

For HNE Use Only
- ❏ Current HNE member
- ❏ Benefit effective >4 months ago
- ❏ Receipts/contract that reflect payment
- ❏ Amount to be reimbursed $____________
- ❏ Fitness coverage effective for __________

Subscriber Information (person in whose name coverage is held):

Subscriber ID Number: ______________________________

Subscriber's Last Name: ________________________ First Name: ________________________

Street Address: __________________________ City: ____________ State: _____ Zip ______

Employer's Name: ____

Member Information (please include the names of all covered family members for whom you are submitting a request for reimbursement):

Member's Name *(first & last)*	Relationship to Subscriber	Indicate Weight Watchers® or Name of Health Club	Effective Date*	Amount Paid

* *To be eligible for fitness reimbursement, the effective date of your coverage with Health New England can be no later than September 1st of the calendar year.*

You must also include:

FOR HNE FITNESS PROMOTION:

- A copy of the health club contract or membership agreement.
- Dated, original receipts from your health club, or copies of bank or credit card statements for electronic fund transfer payments. The receipts must include the member's name and the individual charges for each health club membership.

FOR HNE WEIGHT WATCHERS® REIMBURSEMENT PROGRAM:

- A copy (front and back) of your stamped Weight Watchers® Membership Book. *(Please feel free to black out your weight.)*
- Proof of payment (receipts or copies of bank or credit card statements). Proof of payment must include the member's name and charges for Weight Watchers® sessions

All reimbursements will be sent to the Subscriber's address currently on file with HNE. Maximum reimbursement is $150 per family per calendar year. Please see the eligibility requirements in this brochure.

CERTIFICATION AND AUTHORIZATION *(This form must be signed and dated by each covered family member aged 18 and older.)*

I authorize the release of any information to HNE about my health club membership and utilization and/or my participation in Weight Watchers®. I certify that the information provided in support of this submission is complete and correct and that I have not previously submitted a request for reimbursement.

Subscriber signature: ______________________________ Date: ______________

Covered Member signature: __________________________ Date: ______________

Covered Member signature: __________________________ Date: ______________

Covered Member signature: __________________________ Date: ______________

Please return a completed copy of this form (keep the original for your files), along with your receipts or proof of payment, fitness club agreements and/or stamped Weight Watchers® Membership Book to:

Health New England, Claims Department, One Monarch Place, Suite 1500, Springfield, MA 01144-1500

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