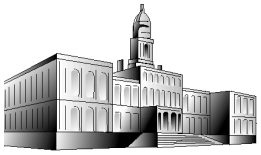
Management Benefits Fund (MBF)

Health Club Reimbursement Program Claim Form

- PLEASE PRINT -



I. CHECK ONE: *(A separate form must be completed for each claimant.)*

☐ MBF MEMBER ☐ MBF MEMBER SPOUSE/DOMESTIC PARTNER

II. MBF MEMBER INFORMATION:

SOCIAL SECURITY #: - -	AGENCY NAME:		
LAST NAME:	FIRST NAME:		M.I.:
ADDRESS:	CITY:	STATE:	ZIP CODE:
WORK TELEPHONE NUMBER: - -	HOME TELEPHONE NUMBER: - -		

III. SPOUSE/DOMESTIC PARTNER INFORMATION: *(To be completed only if claimant is MBF member's spouse/domestic partner)*

LAST NAME:	FIRST NAME:	M.I.:

IV. DIRECT DEPOSIT VIA PERSONAL ACCOUNT INFORMATION: *(Only available to employees of the Unified Court System and retired members) All active employees will be reimbursed through their regular paycheck.*

ACCOUNT TYPE: (CHECK ONLY ONE) ☐ SAVINGS ☐ CHECKING	PERSONS NAMED ON ACCOUNT: (PRINT EXACTLY - INCLUDE TRUSTEE OR JOINT OWNER) PERSON 1:_____ PERSON 2:_____	ABA NUMBER* ACCOUNT NUMBER**

***ABA BANK NUMBER:** CHECKING ACCOUNTS - THE ABA NUMBER IS THE FIRST NINE (9) NUMBERS PRIOR TO THE ACCOUNT NUMBER AT THE BOTTOM LEFT CORNER OF THE CHECK. SAVINGS ACCOUNTS - CONTACT YOUR BANK FOR THE ABA NUMBER, IF NOT KNOWN. ****ACCOUNT NUMBER:** SEE CHECK, PASSBOOK, OR ACCOUNT STATEMENT FOR ACCOUNT NUMBER.

V. CLAIM PERIOD *(Please indicate a six (6) month claim period only.)*

BEGIN DATE: MM/DD/YYYY END DATE: MM/DD/YYYY (End date must not exceed two (2) years from date of claim submission.)

VI. SIGNATURE

By signing this form, the claimant hereby acknowledes that MBF has not given any medical advice nor has recommended participation in this benefit.* The claimant certifies that he or she has no current medical condition that would prohibit participation in an exercise program. The claimant further acknowledges that MBF bears no liability resulting from any injuries or damages arising from use of this benefit. The claimant hereby certifies that he or she has participated in a fitness program and attended a minimum of five times per month for six consecutive months. The claimant understands that the dollar value of this benefit will be included as taxable income to the MBF member.

The claimant hereby authorizes MBF to deposit his or her Health Club reimbursement directly into his or her checking or savings account as requested, if applicable. The claimant also grants authorization for the reversal of a credit to the account in the event the credit was made in error. The claimant understands that, under the "National Automated Clearing House Association" operating guidelines and rules, MBF can only reverse the amount of the incorrect direct deposit. The claimant must provide direct deposit information for each claim submitted.

MEMBER'S SIGNATURE:_____ DATE:_____/_____/_____
Required

SPOUSE'S/DOMESTIC PARTNER'S SIGNATURE:_____ DATE:_____/_____/_____
Spouse's/domestic partner's claim cannot be processed without member's signature.

**** Prior to participating in this benefit, the Management Benefits Fund recommends that you consult with your own physician.***

VII. HEALTH CLUB FITNESS FACILITY AND MEMBERSHIP INFORMATION: *(Please print.)*

FACILITY NAME:	NAME OF FACILITY MANAGER		
ADDRESS:	CITY:	STATE:	ZIP CODE:
TELEPHONE NUMBER: - -	FEDERAL TAX I.D.#:		

DATE CURRENT MEMBERSHIP PURCHASED: MM/DD/YYYY TYPE OF MEMBERSHIP PURCHASED: ☐ INDIVIDUAL ☐ FAMILY**

TYPE OF MEMBERSHIP PURCHASED***:

☐ MONTHLY: $_____ ☐ SEMI-ANNUALLY: $_____

☐ ANNUALLY: $_____ ☐ BI-ANNUALLY: $_____ ☐ TRI-ANNUALLY: $_____

***** If your membership is a family contract, this payment will be prorated.*** ****** Please attach a payment receipt or contract from health club.***

VIII. PROGRAM VALIDATION: *(To be signed by Facility Manager)*

I hereby certify that the facility described above has a fitness program and that the member attended the facility a minimum of five times a month for six consecutive months.

FACILITY MANAGER'S SIGNATURE:_____ DATE:_____/_____/_____

Please see the reverse side for Claim Filing Guidelines. →

- CLAIM FILING GUIDELINES -

1. The MBF member and/or MBF spouse/domestic partner and the facility manager from your fitness facility must complete this form.
2. You are eligible for reimbursement after completing six consecutive months of regular exercise at an MBF approved health club.
3. After each six-month period, you will be reimbursed up to a maximum of $250.00. This benefit will be included in taxable income to the MBF member in the year in which it is received. Claim forms are available through the MBF web site at http://nyc.gov/html/olr or by calling (212) 306-7290. Outside NYC call toll-free at (888) 4000-MBF (623). Please mail completed claim form to: Management Benefits Fund, 40 Rector Street, 3rd Floor, New York, NY 10006
4. You must complete a separate claim form for each consecutive six-month exercise period and attach a copy of the payment receipt. Please note that only the MBF member and MBF member's spouse/domestic partner are eligible for this benefit. Other dependents are not eligible for this benefit.
5. MBF reserves the right to request additional documentation and/or deny any claims.