

Harvard Pilgrim 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 _____