



MASSACHUSETTS
**LABORERS' HEALTH &
WELFARE FUND**

Fitness Reimbursement Form

The Plan provides a fitness reimbursement benefit up to \$150.00 per calendar year for each member and spouse who have (1) **had a routine physical** within 12 months preceding the reimbursement submission and (2) can provide sufficient proof of at least 4 months of a paid membership at a qualified health club for the calendar year for which the reimbursement is sought.

Please visit the Fund's website at <https://www.mlbf.org/health-welfare> for additional information on what expenses qualify for fitness reimbursement under your plan and other FAQs.

PLEASE PRINT ALL INFORMATION CLEARLY.

Member Information:

Member Name _____ Member ID# _____

Member Address _____

Date of Birth _____ Phone Number _____

Claim Information:

Patient Name _____ Date of Birth _____

Relationship: Member (self) Spouse Ex-Spouse

Name and Address of Qualified Fitness Program:

Total Reimbursement Requested: \$ _____ for (select one): _____ Calendar Year: _____

Membership fees. Monthly membership fee: \$ _____

Fitness class fees. Fee per class: \$ _____

Certification and Authorization (this form must be signed and dated below)

I certify that the information provided in support of this submission is complete and correct and that I have not previously submitted for these services. I understand that MLBF requires proof of payment for a reimbursement decision. I authorize the release of any information about my qualified fitness program to MLBF.

Subscriber's or Member's Signature: _____ Date: _____