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

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: _____

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