WELL SENSE HEALTH PLAN

wellsense.org | 877-957-1300

Fitness Reimbursement Form

When to Submit this Form:

- After you've been a member of a health or fitness club and Well Sense Health Plan at the same time for at least three months in a calendar year. Reimbursement is up to $200 per family per year.
- You must submit no later than March 31 of the following year.

Member Information (Please print information clearly)			
YOUR MEMBER ID NUMBER (FOUND ON YOUR WELL SENSE HEALTH PLAN ID CARD)			
MEMBER'S LAST NAME			
FIRST NAME		MIDDLE INITIAL	
ADDRESS	CITY	STATE	ZIP CODE
PHONE			

Health Club Information (Required)			
Attach 8 ½" x 11" photocopies of dated, paid health club receipts, bank/credit card statements, or paycheck stub along with a copy of your Health Club Agreement)			
NAME OF HEALTH CLUB			
ADDRESS	CITY	STATE	ZIP CODE
TOTAL NUMBER OF RECEIPT COPIES ATTACHED	REIMBURSEMENT AMOUNT REQUESTED		

CERTIFICATION AND AUTHORIZATION (this form must be signed below)
I authorize the release of any information to Well Sense Health Plan about my health club membership. 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.

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Member's Signature

Please fold and mail this form (including copies of required documents) to:

Well Sense Health Plan
Fitness Reimbursement
529 Main Street, Suite 500
Charlestown, MA 02129

Well Sense Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: Si habla Español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-957-1300 (TTY: 711).
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-957-1300 (TTY: 711).