



Get Fit! Reimbursement Form

wellsense.org | 877-957-1300

As a Well Sense Health Plan members, your health is our top priority. That’s why we offer reimbursements for fitness club memberships or fitness tracker purchases, and Weight Watchers® programs. This is a total value of up to \$300 per year!

Who Should Submit this Form?

- Must be a Well Sense member for at least 3 months in a calendar year before requesting a fitness tracker, Weight Watchers, or fitness club reimbursement (must be a Well Sense member at the same time as purchase, subscription, or membership).
- You may get reimbursed for a fitness tracker –OR– a gym membership in the same calendar year, **but not both**.
- Reimbursement forms are due by 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			

Member Extra(s) Requested	
<input type="checkbox"/>	Fitness Reimbursement (Up to \$200 per family per year)
<input type="checkbox"/>	Fitness Tracker (50% back, up to \$100 per family per year) A fitness tracker is a digital device such as a smart watch or pedometer that can be worn and tracks your health & activity levels. Smart phones do not qualify.
<input type="checkbox"/>	Weight Watchers Reimbursement (Up to \$100 per year)

To be completed by member		
	Amount Requested	Additional Documentation Needed
Fitness Club Name:		Attach 8 ½” x 11” copies of dated, paid receipts, bank/credit card statements or paycheck stub and copy of your Health Club Agreement.
Fitness Tracker Product Name:		Receipts for fitness tracker must clearly state the item being purchased.
Weight Watcher’s Location:		Confirmation form from Weight Watchers.



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CERTIFICATION AND AUTHORIZATION (this form must be signed by writing or typing in your full name below)
I authorize the release of any information to Well Sense Health Plan about my health/fitness & Weight watchers club membership or health tracker purchase. 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.

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

OR: Fax form & required documents to 617-897-0884

OR: Email this form (including scans of required documents) to: IncomingMarketingMail@BMCHP-wellsense.org

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).