FRESENIUS MEDICAL CARE
Policy # 717297

UnitedHealthcare
A UnitedHealth Group Company

$150 ANNUAL
FITNESS REIMBURSEMENT FORM

Employee Name:_____ALT ID/SSN:_____Date of Birth:__/__/____

Check If
Employee Address:_____ New Address ☐

Health Club Enrolled Member:_____Relationship to EE_____

Eligible: Memberships to gyms, fitness studios, fitness apps, fitness streaming services; home fitness equipment and wearable devices. Reimbursement up to $150 dollars MAX per calendar year in total based on qualified receipts. All reimbursements will be made payable and processed under the employee's record. If you have questions, please call the Customer Care number on your card.

REQUIRED INFORMATION:

Product or Health Facility Name: _____

Health Facility Address: _____

Health Facility Phone Number: _____

Number of Pages with Copies/receipts attached:_____

Total Amount submitted for reimbursement: _____

INSTRUCTIONS:
Please mail this form with photocopies of dated, proof of payment for health club enrollment. Any reimbursements must be received by UHC by March 31st of the following year. Mailing Address: UnitedHealthcare, P. O. Box 740800, Atlanta, GA 30374-0800.

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY MISREPRESENTATION OR ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW AND MAY BE SUBJECT TO CIVIL PENALTIES.

Employee Signature:_____Date:_____/_____/_____

INTERNAL USE ONLY

- ***FOR PROCESSING USE: Code S9970, Place of Service (POS) is "OL", DX code Z0000, TIN- 0-69000005-00001***

FOR UNITED HEALTHCARE USE ONLY

DATE BENEFITS BECAME EFFECTIVE MO. DAY YEAR MO. DAY YEAR Emp. | | Dep. | |	DATE BENEFITS TERMINATED MO. DAY YEAR MO. DAY YEAR Emp. | | Dep. | |	SUFFIX	ACCOUNT
SIGNATURE OF UNITED HEALTHCARE EMPLOYEE CERTIFYING BENEFITS:		DATE (MO. | DAY | YEAR) | |	