# STATE OF MARYLAND
# WEIGHT LOSS REIMBURSEMENT FORM

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| **Weight Loss Program Reimbursement**<br><br>All enrolled employees, retirees and covered spouses (not enrolled children). | Payable at 100% up to an annual maximum of $150 per enrolled employee, retiree or covered spouse.<br><br>Qualifying weight loss programs include all weight loss programs on-site and/or online.<br><br>Excludes:<br>- Fees paid for food, books, videos, scales, or other items not included as part of the fee for the course or class;<br>- penalties of fees; and<br>- credit card receipts are not acceptable. |

*How to File Your Fitness/Weight Loss Reimbursement Claim*

You and/or your covered dependents are eligible to receive reimbursement for the weight loss benefit provided it meets the plan requirements. To request reimbursement, complete a UHC Weight Loss Reimbursement form available on uhcmaryland.com and mail it with the required documentation to the address noted on the form. Please note that the required documentation must be an actual receipt from the program and that credit card receipts are not accepted.

PLEASE PRINT ALL INFORMATION CLEARLY

| **MEMBER INFORMATION (**Person in which coverage is held**)** | | | |
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| **UnitedHealthcare ID Number** | **Employee's Last Name** | **First Name** | **Middle Initial** |
| **Plan Number** **716450** **716451** | | | |
| **Address-Number & Street** | **City** | **State** | **Zip Code** |
| **Email Address** | **Phone #** | | |

**WHEN TO SUBMIT THIS FORM**:

- **After you have collected paid receipts for your qualified Weight Loss Program.**
- **This benefit allows for a $150 annual maximum reimbursement based on the plan year (January-December) for enrolled employees, eligible retirees and spouses. (Enrolled children are not eligible)**

**INFORMATION REQUIRED**

Attach itemized 8.5 x 11 photocopies of paid receipts and a copy of your weight loss program contract. Credit Card receipts will not be accepted.

| Please identify the name of the Weight Loss Program being submitted for reimbursement:<br>• Weight loss membership (Code S9449) | Date Weight Loss Program began: | Total amount submitted for reimbursement: |
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| | TOTAL CHARGES: $ | |

CERTIFICATION AND AUTHORIZATION (This form must be signed and dated below) I authorize the release of any information to UnitedHealthcare, Inc. about my weight loss reimbursement. 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, during this plan year. All weight loss payments will be sent to the Member's address on file.

Member's Signature: Date:

Please mail this form (including copies of paid receipts) to:
UnitedHealthcare
PO Box 740800
Atlanta, GA 30374-0800