HealthPlans
A HARVARD PILGRIM COMPANY

# Weight Loss Program Reimbursement Form

**Employer Name:** _____ **Group Number:** _____

## WHAT TYPES OF WEIGHT LOSS PROGRAMS QUALIFY UNDER THIS BENEFIT?

- Weight loss programs such as Weight Watchers®, Jenny Craig or other weight loss programs qualify.
- Examples of programs that DO NOT qualify for reimbursement include: fees for personal trainers or instruction-only classes; membership fees for tennis, aerobic or pool-only facilities; fees for sports teams and leagues.

## WHEN TO SUBMIT THIS FORM:

- Please refer to your Plan Document or your Summary of Benefits and Coverage for specific details concerning this benefit, including limits and/or restrictions, under your plan.
- Once all sections have been completely filled out and signed by the employee, please mail the completed form with all necessary documentation (copies of receipts and weight loss program registration form) to:

**Health Plans, Inc., PO Box 5199, Westborough, MA 01581**

## To Be Completed by Employee

| *Employee Last Name* | *First Name* | *MI* | *Health Plans Member ID #* | *Date of Birth* |
|---|---|---|---|---|
| | | | | |

| *Mailing Address* | *City* | *ST* | *ZIP Code* | *Home Phone* | *Email Address* |
|---|---|---|---|---|---|
| | | | | | |

## Member/Dependent Information

Reimbursement is requested for the following participant (please check): ☐ Employee ☐ Spouse ☐ Child

If reimbursement is requested for a participant *other than the employee*, please provide the dependent information below:

| *Last Name* | *First Name* | *MI* | *Gender* | *Date of Birth* | *Relationship* |
|---|---|---|---|---|---|
| | | | | | |

## Weight Loss Program Information

Please provide the following information about the weight loss program(s) for which you are claiming reimbursement:

| DATES ATTENDED: From: MM/DD/YYYY To: MM/DD/YYYY | WEIGHT LOSS PROGRAM NAME | ADDRESS, CITY & STATE | PHONE NUMBER *(including Area Code)* | $ AMOUNT CLAIMED |
|---|---|---|---|---|
| – | | | | |
| – | | | | |
| – | | | | |
| – | | | | |

**I certify that the information on the form and all supporting documents are complete, accurate and unaltered.**

**Signature:** _____ _____

*Signature of Employee* *Date Signed*

Submit this completed form, along with copies of your payment receipts and your registration form, to:

**Health Plans, Inc., PO Box 5199, Westborough, MA 01581**