



# WELLBEING REIMBURSEMENT FORM

## ELIGIBILITY:

- Benefit-Eligible Employees and Adult Members (excluding Retirees) of the YourChoice Health Plan are eligible for up to \$250 reimbursement of eligible wellbeing expenses each program year.
- Refer to the Program Guidelines for a complete list of eligible and ineligible expenses.

## REIMBURSEMENT DATES AND DEADLINES:

- Quarterly Submission Deadlines: March 31, June 30, September 30, December 31
- Reimbursement received in the employee's paycheck the following quarter

Reimbursement Form Submitted	Reimbursement paid	Applied to Benefit Year
January 1 - September 30, 2020	January 2021	2020
October 1 – December 31, 2020	April 2021	2020
January 1 – March 31, 2021	July 2021	2021
April 1 – June 30, 2021	October 2021	2021
July 1 – September 30, 2021	January 2022	2021
October 1 – December 31, 2021	April 2022	2021

- The Wellbeing Reimbursement program operates on a calendar-year schedule. So, wellbeing expenses incurred Jan 1 – Dec 31 will be reimbursed and applied to the employee's annual \$250 Wellbeing Reimbursement benefit.
- The activity must be completed during the program year. Reimbursement is based on participation date not payment date. For example: If you pay for a 5K in November 2020 but the race is in January 2021, then that event would be submitted in 2021.
- The wellbeing product or services purchased must be clearly stated on the receipt for the claim to be approved. All reimbursements are subject to Wellbeing Committee approval. The submission is reviewed against eligibility criteria, list of approved expenses, amount left for reimbursement and proof of attendance.

## COMPLETE BOTH SIDES OF THIS FORM

**Pease double-check and be sure to include the following information. Your reimbursement can not be processed without it.**

Name       Aetna W#       Employee ID #       Receipts       Proof of participation

### PARTICIPANT INFORMATION

Participant's Name: \_\_\_\_\_ Aetna W# (if Health Plan Member): \_\_\_\_\_

Employee Status:  Employee     Spouse     Dependent Age 19+      Date of Birth: \_\_\_\_\_

Work or Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Complete other side





# WELLBEING REIMBURSEMENT FORM

## EMPLOYEE INFORMATION

Employee Name: \_\_\_\_\_

Employee ID# \_\_\_\_\_ Employee Agency: \_\_\_\_\_

Total \$ amount of reimbursement [must match receipt(s)]: \$ \_\_\_\_\_ Expenses are being submitted for year 20 \_\_\_\_\_

## PARTICIPANT SIGNATURE

Participant Printed Name: \_\_\_\_\_ Date Submitted: \_\_\_\_/\_\_\_\_/\_\_\_\_

Participant Signature: \_\_\_\_\_

## RECEIPT SUMMARY

THIS SECTION MUST BE COMPLETED BY ALL MEMBERS REQUESTING WELLBEING REIMBURSEMENT. INCLUDE ALL ACTIVITIES TO BE REIMBURSED.

ACTIVITY	DATE OF SERVICE	PRICE PAID	\$ TO BE REIMBURSED
		\$ <input type="checkbox"/> RECEIPT ATTACHED	
		\$ <input type="checkbox"/> RECEIPT ATTACHED	
		\$ <input type="checkbox"/> RECEIPT ATTACHED	
		\$ <input type="checkbox"/> RECEIPT ATTACHED	
		\$ <input type="checkbox"/> RECEIPT ATTACHED	
		\$ <input type="checkbox"/> RECEIPT ATTACHED	

TOTAL \$ AMOUNT TO BE REIMBURSED: \_\_\_\_\_

### SUBMIT WELLBEING REIMBURSEMENT FORM AND SUPPORTING DOCUMENTATION TO:

Mail, fax or email (scanned) accepted.

Manatee YourChoice Fitness Center  
Attn: Wellbeing Reimbursement  
1012B Manatee Avenue  
Bradenton, FL 34205

Phone: 941-748-4501 x3969  
Fax: 941-749-3093  
Email: reimbursement@manateeyourchoice.com

**For Fitness Center Use Only**

Amount submitted for reimbursement: \$ \_\_\_\_\_ Calendar Year \_\_\_\_\_

Approved By: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

