

Reimbursement Form

GENAVIX HealthyCare “90 Day Commit to Get Fit Program”

This form must be completed by the Harvard Pilgrim Health Care **subscriber**. Please use blue or black ink and print clearly.

Instructions:

- After you have completed the 90 Day Commit to Get Fit Program, complete the form below.
- Include a copy of your receipts (cash/check/credit/electronic) for completion of the course.
- *Mail this form and all required documentation to:* Harvard Pilgrim Health Care, P.O. Box 9185, Quincy, MA 02269. **Please allow 6-8 weeks for processing.** We must receive all required documents by March 31 of the following year.

Information about reimbursement:

- Subscribers are eligible for reimbursement **once per calendar year**.
- Reimbursement will be made only **after completion of the program**; members are credited for the year they complete the course. *Example:* If the members participate in the program from November 2013 through January 2014, the subscriber will receive reimbursement for the 2014 calendar year.
- Subscribers who receive reimbursement for the 90 Day Commit to Get Fit Reimbursement **are not eligible** to receive additional reimbursement through Harvard Pilgrim’s standard fitness reimbursement program.

Harvard Pilgrim ID Number	Subscriber’s Last Name	First Name	Middle Initial
Date of Birth (mm/dd/yyyy)	Social Security Number (at least last four digits)		
Address	City	State	ZIP Code
Daytime Phone (area code) xxx-xxxx	Company Name (Employer)	Subscriber’s Email	

Section B – Subscriber and/or Member Information for Reimbursement

Harvard Pilgrim ID Number	Last Name	First Name	Date of Birth (mm/dd/yyyy)
Harvard Pilgrim ID Number	Last Name	First Name	Date of Birth (mm/dd/yyyy)
Harvard Pilgrim ID Number	Last Name	First Name	Date of Birth (mm/dd/yyyy)

Section C – Health Club Information (List all health clubs that you and/or your dependent(s) are submitting for reimbursement listing the qualifying four consecutive months.)

ATTACH DOCUMENTATION	Calendar Year From: mm/dd/yyyy To: mm/dd/yyyy	Program name	City, State	Phone number (Area Code) xxx-xxxx	\$ Amount being claimed
	From: ___/___/____ To: ___/___/____	90 Day Commit to Get Fit			

Total number of documents _____

 Total dollar amount being claimed \$ _____
 up to \$150 per calendar year

Section D – Subscriber Certification

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

Subscriber’s Signature _____

Date _____