Information about the Fitness or Weight Loss Reimbursement Through BBA

- BBA Plan Year is February 1st through January 31st each year.
- Employees enrolled in health insurance through Haartz health plan with BBA can receive up to $150 for Fitness AND/OR Weight Loss Reimbursements per plan year.
- Both employees and enrolled dependents are eligible for the program however it is a maximum of $150 for either benefit (fitness and/or weight loss) regardless if the employee is on an individual plan or a family plan.

How to Claim Your Fitness or Weight Loss Reimbursement Through BBA

1. Pay at least 4 months of fees towards your program- this is required in order to be eligible for reimbursement.
2. Complete the form below.
3. Collect documentation of payment from your fitness or weight loss provider.
4. Submit the reimbursement form AND the payment documentation to BBA via mail (the address on the form) or via fax to (603) 773-4430.
5. Make sure you submit your reimbursement no later than March 31st following the end of each plan year.

Please contact Human Resources with any questions about Fitness & Weight Loss Reimbursements!

Mail to:
Blue Benefit Administrators of Massachusetts
P.O Box 55917
Boston, MA 02205 - 5917

BLUE Benefit ADMINISTRATORS OF MASSACHUSETTS

Fitness, Health & Wellness Form

*The below information and examples are **NOT** inclusive, and do **NOT** encompass all information and plan specific requirements for reimbursement. Some plans may require the completion of several classes or months of paid membership prior to reimbursement. The below benefit type choices are not a guarantee that your plan has that specific Wellness, Health or fitness option.* ***Please refer to your Summary Plan Description (SPD) for specific details on your Fitness/Health or Wellness Plan.***

This claim form must be accompanied by a copy of an itemized bill on provider letterhead to be eligible for plan reimbursement. You must complete each of the sections below.

SECTION 1: EMPLOYEE INFORMATION

NAME	SEX	DATE OF BIRTH
	MALE ☐ FEMALE ☐	
STREET ADDRESS	HOME PHONE NO.	
CITY, STATE, ZIP CODE	MEMBER IDENTIFICATION NUMBER	

SECTION I1: CLAIMANT INFORMATION

NAME	DATE OF BIRTH	SEX	RELATION
		MALE ☐ FEMALE ☐	SELF ☐ SPOUSE ☐ DOMESTIC PARTNER ☐
STREET ADDRESS		HOME PHONE NO.	
CITY, STATE, ZIP CODE		SOCIAL SECURITY NO.	

SECTION III: BENEFIT TYPE (Please refer to the Summary Plan Description Specific Coverage Details.)

☐ **Fitness** - *Health club membership fees, fitness classes, personal training with professional instructor, qualified sport teams and leagues*

☐ **Weight loss** – *Weight loss programs such as Weight Watchers, Jenny Craig, hospital-based programs, Employer sponsored programs*

☐ **Health & Wellness** – *Weight loss programs, health clubs, massage therapy, hypnotherapy, smoking cessation, Employer sponsored programs*

☐ **Fitness & Weight Loss** - *Health club membership fees, fitness classes, personal training with professional instructor, qualified sport teams and leagues Weight loss programs such as Weight Watchers, Jenny Craig, hospital-based programs, Employer sponsored programs*

To be eligible for reimbursement the covered person must file a claim and a paid receipt/itemized statement from the rendering provider no later than specified date per plan guidelines found in Summary Plan Description.

Members Statement

I certify that the above is complete and correct and that I am claiming benefits only for charges incurred by the patient above. Authorization is hereby given to any hospital, physician, or other provider which participated in any way in my care and treatment to release to BBA any information which they in their judgment deem necessary to the adjudication of this claim.

Member Name

Electronic Member Signature

Date