



Wellness Facility Reimbursement Form

Employee Name

Name of Health Club

Quarter/Year

Please attach proof of payment of fees and attendance (12 visits per quarter) by employee, or a family member enrolled in the Company-provided Medical Plan.

Month	Name of Attendee	Amount Paid	Max Reimb.
Total			

Total to be Reimbursed To Employee
(lesser of amount paid or max. reimb.)

My signature verifies attendance at the health club listed above by me, or a family member who is enrolled in the Company-provided Medical Plan.

Signature

Date

Calendar Quarter	Due Date	Reimbursement via Payroll Check
January - March	April 15th	April 30th
April - June	July 15th	July 31st
July - September	October 15th	October 31st
October - December	January 15th	January 31st

Please return completed form with appropriate documentation to the PR/HRIS Specialist.

Monthly Reimbursement Maximum Amounts:
January to December 2023, \$48