Mamaroneck Union Free School District

Gym Reimbursement Form

UMR
A UnitedHealthcare Company

Group# **76412995**

Please complete this form and submit with supporting documents (select 1).

Online: Through your **umr.com** member portal

Mail:
UMR, P.O. Box 30541, Salt Lake City, UT 84130-0541

Fax: **855-444-2896**

Personal information

Member name _____ Member ID _____ Date of birth ___/___/___ (MM DD YYYY)

Address _____

Member phone number ___-___-___ Member email _____

6-month period requested Start date ___/___/___ (MM DD YYYY) End date ___/___/___ (MM DD YYYY)

About your benefit:

- 100% covered for only employee and spouse
- Employee: $200 reimbursement per 6-month period
- Spouse: $100 reimbursement per 6-month period
- Covered person must complete a minimum of 50 visits per 6-month period to receive reimbursement

Dates of your 50 gym visits* (MM/DD/YYYY)

1. ___/___/___	11. ___/___/___	21. ___/___/___	31. ___/___/___	41. ___/___/___
2. ___/___/___	12. ___/___/___	22. ___/___/___	32. ___/___/___	42. ___/___/___
3. ___/___/___	13. ___/___/___	23. ___/___/___	33. ___/___/___	43. ___/___/___
4. ___/___/___	14. ___/___/___	24. ___/___/___	34. ___/___/___	44. ___/___/___
5. ___/___/___	15. ___/___/___	25. ___/___/___	35. ___/___/___	45. ___/___/___
6. ___/___/___	16. ___/___/___	26. ___/___/___	36. ___/___/___	46. ___/___/___
7. ___/___/___	17. ___/___/___	27. ___/___/___	37. ___/___/___	47. ___/___/___
8. ___/___/___	18. ___/___/___	28. ___/___/___	38. ___/___/___	48. ___/___/___
9. ___/___/___	19. ___/___/___	29. ___/___/___	39. ___/___/___	49. ___/___/___
10. ___/___/___	20. ___/___/___	30. ___/___/___	40. ___/___/___	50. ___/___/___

*As a substitute for filling in the dates of your 50 gym visits on this form, you may submit one of the pieces of documentation listed below as an attachment to this form. Your documentation must include a signature from a gym representative for verification purposes.

- Proof of gym membership
- Printed list of your visits to the fitness center
- Receipts that show each time you visited the gym

Or

Gym name _____

Gym employee signature _____

Gym employee's signature above constitutes agreement that the facility promotes cardiovascular wellness for members. False statements will result in the denial of reimbursement.

My signature below affirms all information listed above is full, complete and true to the best of my knowledge.

Member signature _____ Date ___/___/___ (MM DD YYYY)