

LifeStyle Reimbursement Program
EPISD Health Care Trust Medical Plan
Application for Reimbursement

Employee Name: _____	SSN: _____
Address: _____	City, State, Zip: _____
Phone (Home): _____	Phone (Work): _____
School Location or Facility: _____	
Claimant Name: _____	
Email address: _____	

Please answer the questions below so we may better serve you through your wellness program.

Name of Exercise Facility: _____
Start Date of Wellness Program: _____ Start Date at Facility: _____
This application for reimbursement is for the months of _____ through _____
Average number of workouts per month (circle one) 8 10 12 14 16+
Are you working out more often than before you started your membership? More vigorously? _____
Do you plan to keep your membership at the same facility? Yes No If not, please explain why you are terminating your membership or let us know if you have chosen another fitness facility. _____
How has your participation in the LifeStyle Reimbursement Program inspired your overall health and well-being? (Please be specific) _____

NOTICE: Employee must be a participant in the EPISD Health Care Trust Medical Plan (Classic or Standard Option) to be eligible for the LifeStyle Reimbursement.

Application must be for: Six (6) consecutive months, 8 visits per month. Will reimburse up to \$15 per month.

Attachments required for reimbursement:

- 1. Application for reimbursement, 2. attendance record, 3. proof of monthly payments,**
- 4. Copy of fitness center application, membership agreement, contract or renewal.**

Employee Signature: _____ Date: _____

For information on the EPISD Wellness Programs log-in to www.episdbenefits.org