NY Standard Gym Benefit Reimbursement

Available on select Independent Health plans, the NY Standard Gym Benefit offers eligible subscribers the opportunity to be reimbursed up to $200 per six-month period for a gym membership and up to $100 per six-month plan for their covered spouse each year.¹ You can get reimbursed for going to the gym an average of two to three times per week. Reimbursement is for the actual six-month cost of the gym membership.

Follow These Steps to Verify Eligibility and Receive Reimbursement for your Fitness Participation:

- **Confirm your eligibility.** Verify your plan includes this benefit. If you need help verifying your eligibility, call Member Services at (716) 631-8701 or 1-800-501-3439.

- **Check if your gym qualifies.** To receive reimbursement, your gym must promote cardiovascular wellness.²

  - For a gym to be considered eligible, it must provide at least two pieces of equipment or activities that promote cardiovascular wellness from the following list:
    - Elliptical Cross-Trainer
    - Group Exercise
    - Pool
    - Rowing Machine
    - Stationary Bicycle
    - Squash/Tennis/Racquetball Court
    - Step Machine
    - Treadmill
    - Walking/Running Group

- **Know your reimbursement period.** The first reimbursement period begins on the start of your insurance plan year, and ends six months from that date. Additional reimbursement periods begin one day after your previous reimbursement period ended. Note: Gym visits cannot carryover from one six-month period to another.

- **Go to the gym.** You must complete at least 50 visits per six-month period. Reimbursements will not be issued until six months have passed, even if 50 visits are completed sooner than six months.

- **Collect paperwork.** You need to provide:
  - A copy of your current gym bill, showing the monthly cost of your membership.
  - A receipt from the gym showing full payment for each of the six months you are submitting for reimbursement.
  - Personal proof of payment (i.e., credit card statement, payroll deduction, automatic bank withdrawal, etc.).³
  - A copy of the brochure that outlines the services the gym offers.

- **Complete the gym reimbursement form.** Have a representative from your gym sign the form (second page of this form). You can get extra forms from our website independenthealth.com, or by calling us at (716) 631-8701 or 1-800-501-3439.

- **Return everything within 120 days of each completed six-month period.**
  - Completed gym reimbursement form
  - Copy of your current gym bill
  - Proof of payment
  - Copy of the gym’s brochure

**Important:** Please complete one claim form per member, for each 6-month period for which you are making a claim. Please complete the form in its entirety, or the processing of your reimbursement may be delayed or denied.

**Send all documentation to:**
Independent Health, Attn: Wellness Department, 511 Farber Lakes Drive, Buffalo, NY 14221

¹Check your Certificate of Coverage or Contract to determine eligibility for this reimbursement.
²Memberships in sports club, country clubs, weight loss clinics, spas or other similar facilities are not eligible.
³On your proof of payment, please be sure to cross out your personal account identification information and other information not relevant to your gym payment so it is not legible.

See next page for Gym Reimbursement Form.
GYM REIMBURSEMENT FORM

Member name: _______________________________________________________________________________________________________

Member address: __________________________________________ City:______________________ State:_____ Zip Code:_________

Independent Health member ID number: ________________________________________ Date of birth: ______________________

DATES OF YOUR 50 GYM VISITS*:

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

*As a substitute for filling-in the dates of your 50 gym visits on this form, you may submit a computer printout listing your visits to the fitness center with the signature from a facility representative as an attachment to this form. Your documentation must include your name and a signature from a facility representative for verification purposes.

Name of the facility: ____________________________________ Facility employee’s signature: _______________________________

Facility 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 that all of the information listed above is full, complete and true to the best of my knowledge.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Member signature: ________________________________________________________________ Date: ___________________________

If you have any questions regarding your gym reimbursement, please call us at (716) 631 8701 or 1 800 501 3439.

FOR OFFICE USE ONLY:

Member ID:___________________________________________________________________________ Name of Product:____________________________________________________

Approved By:______________________________________________________ Approved Amount:_____________________________________ Logged:__________________________

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