BLUE Benefit
ADMINISTRATORS OF MASSACHUSETTS

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

Phone:: 877-707-2583
Fax: 877.596.2583

APPLICATION FOR **FITNESS & WEIGHT LOSS** CLAIM FORM:

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

SECTION I: EMPLOYEE INFORMATION		
NAME	SEX MALE FEMALE	DATE OF BIRTH
STREET ADDRESS	HOME PHONE NO.	
CITY, STATE, ZIP CODE	MEMBER IDENTIFICATION NUMBER	

SECTION II: CLAIMANT INFORMATION			
NAME	DATE OF BIRTH	SEX MALE FEMALE	RELATION SELF SPOUSE OTHER
STREET ADDRESS		HOME PHONE NO.	
CITY, STATE, ZIP CODE			

SECTION III: BENEFIT TYPE (Refer to the Summary Plan Description for Additional Plan Details)

☐ FITNESS BENEFIT — 100% up to $150 per employee per calendar year for members age 14+ for reimbursement of health club membership fees .A paid receipt must be submitted to the Claims Administrator for processing under provisions of this plan.

☐ WEIGHT LOSS — 100% up to $150 per employee per calendar year reimbursement of weight loss programs (such as Weight Watchers or Jenny Craig) . A paid receipt must be submitted to the Claims Administrator for processing under provisions of this plan.

Submit this claim form along with proof of fitness center membership or weight loss program enrollment, accompanied by proof of payment, and Blue Benefit Administrators of Massachusetts will reimburse you up to the maximum for the period.

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 (please print)_____

Member Signature_____ Date_____