

HAMBURG CENTRAL SCHOOL DISTRICT PHYSICAL AND WELLNESS CLAIM FORM

Please read these instructions before completing the claim form:

1. Employee must be active in Hamburg CSD Health Insurance to be eligible to receive reimbursement. Please complete Part I and Part II and/or Part III whichever is applicable.
2. **Instructions for Part II Wellness Reimbursement:**
The following items are reimbursable from July 1, 2021 to June 30, 2022: Gym, Fitness or Aquatic Membership, Exercise or Yoga Classes., Purchase of Equipment found in a gym, Leagues (promote activity over a sustained period, Miscellaneous (such as Weight Watchers (not food or diet supplements) Exercise DVD;s , Wii Fit Plus software. Attach a copy of your receipt which has the last four digits of your credit card, vendor's name, your name of employee and/or eligible dependent's name and amount paid for the service. Computer generated receipts are not acceptable.
3. **Instructions for Part III Physical Exam:** Must have Physician Script or medical facility letterhead stating Patient's name, date of annual physical, language indicating the visit was for wellness, child's preventative exam, adult preventative exam, annual physical exam, etc. **OB/GYN annual visits are not eligible, DOT, camp and/or work physical exams are not eligible.** Name of physician. Single Plan Participants can earn up to \$100 and Family Plan Participants can earn up to \$200.
4. Mail (or fax) the completed form to the address (or fax number) provided on this form.

Part I: Employee Information (Please Print)

Employer Name: Hamburg Central School	
Employee Name:	Employee Social Security Number:
Address:	New Address? <input type="checkbox"/> YES <input type="checkbox"/> NO
Daytime Phone	Evening Phone

Part II: Wellness Reimbursement

Covered Person	Date of Service	Provider	Amount Claimed	Administrative Use Only
Wellness Reimbursement Total			\$	

Part III: Physical Exam

Name	Date of Service	Provider	Coverage		Amount Claimed	Administrative Use Only
			Single	Family		
Physical Exam Subtotal					\$	
Total Amount Claimed					\$	

Please submit this form for services incurred between July 1, 2021 and June 30, 2022. The deadline to submitting for these expenses is July 15, 2022. Claims are processed on a monthly basis.

Employee Signature: _____ Date: _____

Send completed claim form to:

Health Economics Group, Inc.
1387 Fairport Road, Bldg. 1000, Suite A-1
Fairport, NY 14450

(585) 241-9500, ext. 504
(800) 666-6690, ext. 504
FAX: (585) 241-9518
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