Health Improvement Benefit Reimbursement Form

Please complete the following information and return this form and an ***itemized*** receipt to the Trust offices at the address below. You have exactly six months from date of service to submit your claim for reimbursement. Thank you!

Date of Reimbursement Request: _____

Participant Name: _____ Trust ID #: _____

Address: _____

Phone Number: _____ Date of Birth: _____

Type of Reimbursement (circle one):

Health Club Membership Fees/Dues Personal Training Fees

Tobacco Prevention Fees Weight Management Support Group Fees

Name of Provider: _____

Amount Paid: _____

_____ _____

Signature Date

Remit form and ***itemized*** receipt to:
Wellness Division
Teachers Health Trust
P.O. Box 96238
Las Vegas, NV 89193-6238

For Internal Use Only:

Received by: _____ **Date:** _____

Date Check Request Submitted: _____