

# Harvard Pilgrim Weight Loss Reimbursement Form

Please read the instructions below, then proceed to fill out the Fitness Reimbursement Form.

## Mailing Instructions

Please enclose the following:

**Keep copies of all documentation before sending in your Weight Loss Reimbursement Form.**

1. Completed Reimbursement Form
2. Copy of receipts (cash/check/credit/electronic) for dues clearly documenting your name and the weight loss program name.  
Dues must equal or exceed amount being claimed.
3. Mail to: Harvard Pilgrim Health Care  
P. O. Box 9185  
Quincy, MA 02269

## Commonly Asked Questions and Answers

### How do you qualify for a reimbursement?

- Subscriber must be active with coverage that includes the weight loss program, i.e., a current member of Harvard Pilgrim, at the time of Harvard Pilgrim's receipt of a **complete** reimbursement form.
- Current Harvard Pilgrim membership must be equal to or greater than four consecutive months in length with the Tufts University membership.

### When can you submit your Reimbursement Form?

Starting with May 1 of the current calendar year\* and when you have met the above-stated criteria.

### How much can you claim for reimbursement?

- Reimbursement is up to \$150 per calendar year (e.g., January–December) for single coverage or \$300 per calendar year for family coverage in total for health club membership dues for subscriber and/or their dependents.
- Subscriber may receive reimbursement **only** once for a calendar year.

### What happens once you submit the Reimbursement Form?

- Reimbursement checks will be mailed and made payable to the Subscriber only at the Subscriber's address of record.  
No alternative address will be accepted.
- If you believe your current address is different than the address of record in Harvard Pilgrim's systems, please contact us prior to submitting your form. In most cases we will update your address in our systems directly — in other cases, if applicable, when your employer submits transactions to us electronically, we will ask you to inform your employer of your address change.
- Please allow 6-8 weeks for processing.

*This information refers to plans offered by Harvard Pilgrim Health Care and its affiliates, including Harvard Pilgrim Health Care of New England and HPHC Insurance Company.  
Reimbursement program requirements are subject to change without notice.*

# Harvard Pilgrim Weight Loss Reimbursement Form

To be filled out by Harvard Pilgrim Health Care SUBSCRIBER only. Please use blue or black ink and print all information clearly.

## When to submit this form:

- After you have accumulated \$150 (single coverage) or \$300 (family coverage) in weight loss program expenses.
- Once per calendar year, filed by March 31 of the following year, with all necessary receipts for dues.
- Once all sections have been completely filled out and signed by the Subscriber.
- Programs that qualify: traditional Weight Watchers meetings, at-work programs and hospital-based programs.

## Section A – Subscriber Information (person who holds coverage)

Harvard Pilgrim ID Number	Subscriber's Last Name	First Name	Middle Initial
Date of Birth (mm/dd/yyyy)	Social Security Number (at least last four digits)		
Address	City	State	ZIP Code
Daytime Phone (area code) xxx-xxxx	Company Name (Employer)	Subscriber's Email	

## Section B – Subscriber and/or Member Information for Reimbursement

Harvard Pilgrim ID Number	Last Name	First Name	Date of Birth (mm/dd/yyyy)
Harvard Pilgrim ID Number	Last Name	First Name	Date of Birth (mm/dd/yyyy)
Harvard Pilgrim ID Number	Last Name	First Name	Date of Birth (mm/dd/yyyy)

## Section C – Weight Loss Program Information (List all programs that you and/or your dependent(s) are submitting for reimbursement.)

ATTACH DOCUMENTATION	Calendar Year	Program Name	City, State	Phone Number (Area Code) xxx-xxxx	\$ Amount being claimed
	From: mm/dd/yyyy To: mm/dd/yyyy				
	From: ___ / ___ / ___ To: ___ / ___ / ___				
	From: ___ / ___ / ___ To: ___ / ___ / ___				
	From: ___ / ___ / ___ To: ___ / ___ / ___				

Total number of documents \_\_\_\_\_

Total dollar amount being claimed \$ \_\_\_\_\_  
up to \$150 per calendar year for single coverage or  
\$300 per calendar year for family coverage

## Section D – Subscriber Certification

I certify that the information on the form and all supporting documents are complete, accurate and unaltered.

Subscriber's Signature \_\_\_\_\_

Date \_\_\_\_\_