Reimbursement form

Member[1] information (please print)			
Member first name:	Member last name:	Date of birth (month/day/year):	
Are you the plan subscriber? (yes/no):	If no, what is your relationship to the plan subscriber? (e.g., spouse, domestic partner):		
Employer/company name:		Group number:	Member ID number:
Member street address:			
City:		State:	ZIP code:

Sweat Equity program 6-month period	
Start date:	End date:

Completing and submitting this form

1. **Use 1 form per member. Record the 50 fitness facility visits and/or classes that you completed in a 6-month period on the chart shown below. Record only 1 session per day. For eligible dependent minors participating in the program, form to be completed by parental/legal guardian.**
2. **Your documentation must include the following:** Record of the 50 fitness facility visits (dates) and/or classes that you completed in a 6-month period. You may send us a computer printout(s) or receipts from your visits, classes and events showing the name of the facility, class or event and your dates of participation, or you may fill in this information on the chart below.
   - The first date you put on the chart is the beginning of your 6-month program
   - Your program will end 6 months from this date. Do not make entries for activity after your program end date.
   - If you complete 50 qualifying workouts in less than 6 months, please do not submit your reimbursement request early. We cannot accept reimbursement requests before 6 months have passed.
3. **Provide fitness facility signature(s):** Your documentation must include signatures from a facility representative, class administrator or event coordinator, as appropriate, to prove participation
4. **Attach proof of payment:** Dated proof of payment (e.g., receipt, payroll deduction, automatic bank withdrawal statement) for the fitness facility fee, as well as any money you paid for fitness classes and events, during the 6-month period*
5. **Mail documentation to:**
   UnitedHealthcare Sweat Equity Program
   P.O. Box 740806
   Atlanta, GA 30374

   These documents must be mailed to us (postmarked) or submitted online no later than 120 days from your program end date. **Requests postmarked or submitted online after this date won't be reimbursed.**

Electronic reimbursement request

You have the option to make your Sweat Equity reimbursement request online if you do not wish to make the request by mail. To make the request online:

- Sign in to **myuhc.com®**
- Click **Claims & Accounts**
- Click **Submit a claim**
- On the **Medical and Mental Health** tile, click **Start a claim** and fill in the required information

*On your proof of payment, please be sure to cross out any personal account ID information that's not needed so it isn't readable.

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Fitness events, facility visits and classes (record only 1 session per day)			
Date (mm/dd/yyyy)	**Session type***	**Date (mm/dd/yyyy)**	**Session type***
1.		26.	
2.		27.	
3.		28.	
4.		29.	
5.		30.	
6.		31.	
7.		32.	
8.		33.	
9.		34.	
10.		35.	
11.		36.	
12.		37.	
13.		38.	
14.		39.	
15.		40.	
16.		41.	
17.		42.	
18.		43.	
19.		44.	
20.		45.	
21.		46.	
22.		47.	
23.		48.	
24.		49.	
25.		50.	

* Indicate "F" for facility/gym; "C" for class, including organized group events (e.g., marathon).

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Fitness event, class, session, facility information	
Organization name:	Organization name (if second one was used):
Organization type:	Organization type:
Address:	Address:
City, State, ZIP code:	City, State, ZIP code:
Telephone number:	Telephone number:
Names of events, classes, sessions you participated in:	

Fitness facility/instructor information			
Facility employee/class instructor name:		Facility employee/class instructor name (if second one was used):	
Signature:	Date:	Signature:	Date:
Instructor's or other facility employee's signature above constitutes agreement that the instructor/facility promotes cardio wellness for members.			

Member verification	
Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. My signature below confirms that all of the information I have provided on this form and attached is full, complete and true to the best of my knowledge. False statements will result in the denial of reimbursement.	
Signature:	Date:

Exclusions and limitations

- Sweat Equity is a voluntary program. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. You should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for you.
- For this program, the use of "you" and "member" in communications refers to the UnitedHealthcare plan subscriber, the subscriber's covered spouse or domestic partner and the subscriber's eligible dependents age 13 or older. For the subscriber's spouse/domestic partner and dependent child(ren) to be eligible for this benefit, they must also be enrolled in the UnitedHealthcare product. The program may not be available to all UnitedHealthcare plan subscribers and their spouses/domestic partners and dependents. Reimbursement is generally limited to the lesser of $200 per subscriber/$100 per covered spouse/domestic partner/eligible dependent age 13 and older or the actual amount of the qualifying fitness costs per 6-month period. Reimbursement may vary by plan. Refer to your Certificate of Coverage or other governing member document to determine eligibility, including your plan's benefit and application deadlines.
- To be eligible for reimbursement under the program, the qualifying facility, class or organized group physical fitness event (e.g., marathon) that you choose must be available to the general public and promote cardiovascular wellness, as determined by us, and have staff supervision.

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- You must be an active employee at the time of your application for reimbursement. You may submit an application for reimbursement under the program once every 6 months (up to 2 times in a plan year). We will reimburse only those qualified visits, sessions or events that were completed while you were a UnitedHealthcare member. We will not reimburse visits, sessions or events that occurred before your coverage became effective or after your coverage terminates. Partial reimbursements will not be given for fewer than 50 workouts in a 6-month period.
- You must hold an active fitness facility or class membership for the facility/class named in the request at the time of your application for reimbursement.
- Memberships in tennis clubs, country clubs, social clubs, sports teams, weight management clinics or spas or any other similar organizations, leagues or facilities will not be reimbursed. We will not reimburse you for the purchase of lessons, equipment, clothing, vitamins or other items or services that may be offered by the facility. Reimbursement is limited to actual workout visits. Physical and rehabilitative therapies do not apply.
- Lifetime memberships are not eligible for reimbursement.
- If you paid for a full-year's facility membership or class enrollment in advance, at the end of the first 6-month period for which you are applying for reimbursement, submit the receipt along with the required documentation noted above for reimbursement against half of the annual fee that you paid. Repeat this process at the end of your second 6-month period for which you made a full-year's payment, providing you have met the requirements for another, consecutive reimbursement.
- Complete 1 form per member for each 6-month period for which you are applying for reimbursement.
- We cannot accept requests for reimbursement before your 6-month program end date, even if you have completed the required number of qualifying workouts before this date.
- If any information is missing from this form, is incorrect or cannot be substantiated, the application for reimbursement will be delayed or denied.
- If you are unable to meet the reimbursement requirements of this program, you might be able to earn the same reward a different way. Call us at the toll-free phone number on your health plan ID card and we will work with you and, if necessary, your doctor to find another way for you to earn the same reward.
- Any information we collect in conjunction with this program is kept confidential according to HIPAA requirements and is separate from and has no effect on a member's medical benefits or premium.

Learn more

Call the phone number on your UnitedHealthcare plan ID card

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[1] On this form, the term "member" refers to the UnitedHealthcare plan subscriber of a fully insured UnitedHealthcare® medical plan, as well as the subscriber's covered spouse or domestic partner and covered dependents age 13 and older. For the spouse, domestic partner or dependent(s) to be eligible for this benefit, they must also be enrolled in the UnitedHealthcare product.

The total annual reward amount for your participation in incentive-based programs cannot exceed 30% of the cost of coverage.

Rewards may be taxable. You should consult with an appropriate tax professional to determine if you have any tax obligations from receiving reimbursement under this program.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates.