Allegiant Care
HEALTH BENEFITS FOR TEAMSTERS

P.O. Box 4604 • 800.258.9732
51 Goffstown Road • 603.669.4771
Manchester, NH 03108 • f 603.666.4477

Health Club Reimbursement

IMPORTANT: Section 3 of this form must be completed by a health club representative. Be sure to provide a detailed attendance record with your completed reimbursement form.

SECTION 1: MEMBER INFORMATION

Member's Full Name	Date of Birth / /	SSN (last 4 digits)
Mailing Address	City	State	Zip Code
Marital Status	Employer
Primary Phone ( )	E-mail Address

SECTION 2: CLAIMANT INFORMATION ❒ Check box if Claimant is the member and skip to Section 3

Claimant's Full Name	SSN (last 4 digits)
Mailing Address (if different)	City	State	Zip Code
Prime Phone Number ( )	E-mail Address	Relationship to Member

SECTION 3: HEALTH CLUB FACILITY (to be completed by health club representative)

Name of Health Club	Phone Number ( )
Name of Health Club Representative completing this form	Job Title
Mailing Address	City	State	Zip Code

I verify that _____ (participant's name) has been an active member of this club for the six month period of ____/____/____ through ____/____/____ and has engaged in physical activity an average of three times per week (approximately 78 visits in a 6 month period).

Health Club Representative Signature: **Date:**

SECTION 4: CERTIFICATION & AUTHORIZATION

I certify that all information provided on this form is complete and accurate and that I have been a member of a supervised health club and have engaged in physical activity an average of three times per week for the period noted above. I authorize Allegiant Care to contact the health club to verify information contained on this claim.

Claimant Signature: _____ **Date:** _____

Failure to provide a detailed attendance record will cause delay in processing or denial of claim.

Return your completed form to the mailing address noted above.
You may also fax it to 603-792-7214 or email claims@myallegiantcare.com.
Retain a copy of this form for your records.