MASSACHUSETTS
LABORERS' HEALTH & WELFARE FUND

Fitness Reimbursement Form

Please visit the Fund's website at www.mlbf.org for additional information on what expenses qualify for fitness reimbursement under your plan. Information can be found on the Health & Welfare FAQs page.

PLEASE PRINT ALL INFORMATION CLEARLY.

Member Information:

Member Name _____ Member ID#. _____

Member Address _____

Date of Birth _____ Phone Number _____

Claim Information:

Patient Name _____ Date of Birth _____

Relationship: Member (self) ☐ Spouse ☐ Ex-Spouse ☐

Name and Address of Qualified fitness Program:

_____

Total Reimbursement Requested: $ _____ for (select one):

Membership fees. Monthly membership fee: $_____ Calendar Year: _____

Fitness class fees. Fee per class: $_____

Certification and Authorization (this form must be signed and dated below)
I certify that the information provided in support of this submission is complete and correct and that I have not previously submitted for these services. I understand that MLBF requires proof of payment for a reimbursement decision. I authorize the release of any information about my qualified fitness program to MLBF.
Subscriber's or Member's Signature:

_____ Date: _____

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