

PLEASE
 DO NOT
 STAPLE
 IN THIS
 AREA



WEIGHT WATCHERS® REIMBURSEMENT FORM

1. Participant's first name: _____ Participant's last name: _____	2. Participant date of birth: Month Day Year <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:33%;"></td> <td style="width:33%;"></td> <td style="width:33%;"></td> </tr> </table>				4. Member's ID #: _____	
5. Member's first name: _____ Member's last name: _____	3. Relation to Member: Self Spouse Child Other <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:25%;"></td> <td style="width:25%;"></td> <td style="width:25%;"></td> <td style="width:25%;"></td> </tr> </table>					
6. Member's Address: _____ _____ _____						

Reimbursement :

- is based on attendance and payment of program costs
- will not be greater than 50% of amount paid-to-date by member
- is based on a minimum of 5 meetings attended and or at end of program if less than 5 remaining

NOTE: Reimbursement checks will be made out to the member and mailed to his/her home address.

Program Location: _____

Program Phone : _____ - _____ - _____

Program Start Date: ___/___/___

Choose one program and complete program information box:

Weight Watchers at Work or Pre-Paid Commitment Program

Total Paid: \$ _____	Number of Weeks: _____	Leader Signature: _____
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Weekly Payment Program

Registration Fee: \$ _____	Leader Signature: _____
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Meeting Attendance Record

Date	Weight Watchers® Leader verifying attendance (print and sign name)	Weekly Paid Amount* (if applicable)

* The benefit covers PROGRAM COSTS ONLY (not books, scales, meals, etc.)
 OSU Health Plan, Inc. reserves the right to verify attendance and payment of services in the program before reimbursement of benefit.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NGS USE ONLY: V65.3 99412
