Get Fit, Get Reimbursed

GET REIMBURSED FOR UP TO $600 — **JUST FOR STAYING ACTIVE!**

Get reimbursed for up to $400 for going to the gym, and your spouse can earn up to $200 for a total of $600 per family!★ Here's how to get started:

1. **Join a Fitness Center**

   You may join any qualified fitness club or exercise center that is open to the general public. Fees paid for attending aerobic/fitness classes at a qualified health club that does not require an annual membership are also eligible for reimbursement. A qualified fitness club or exercise center houses exercise equipment for the purpose of physical exercise. Memberships in sports clubs, country clubs, weight loss clinics, spas, or other similar facilities are not eligible.

2. **Visit the Gym**

   Go to the gym 50 times within six months – about two times per week. Use the Fitness Participation Log to record your visits. Be sure to have it signed by the instructor/facility each time you go. Alternately, you may provide a printed record of your visits from the fitness center or receipts that indicate each time you have visited the center.

3. **Complete the Fitness Reimbursement Form and Submit All Documentation**

   Complete the Fitness Reimbursement Form, along with your fitness participation log(s), a copy of your current bill, and proof of payment. Mail all documentation to:

   CDPHP
   P.O. Box 66602
   Albany, NY 12206

★ Subscriber is entitled to $200 every six months. Spouse is entitled to $100 every six months. See plan contract for complete benefit information.

CDPHP®

A plan for life.

CDPHP® Fitness Reimbursement Form

Use this form to request reimbursement for fitness center fees.
Call member services at the number on your ID card with questions.

1. Member Information

Name: ....

Member ID #: ....

Address: ....

Phone: ....

Employer Name: ....

Date of Birth: ....

2. Fitness Center(s) Information:

FITNESS CENTER NAME	ADDRESS	PHONE NUMBER

Total Number of receipts/documents attached: ....

Total Amount Submitted: ....

3. Certification and Authorization *(must be signed by the subscriber)*

Reimbursement is subject to approval by Capital District Physicians' Health Plan, Inc. I certify that the information on the form and all supporting documents are complete, accurate, and unaltered, and that I am claiming reimbursement only for eligible expense incurred during the applicable plan year and for eligible members. I certify that these expenses have not previously been reimbursed in this or any other year.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

Subscriber's Signature ....

Date: ....

Please mail this form and all supporting documents to:
CDPHP
P.O. Box 66602
Albany, NY 12206

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Fitness Participation Log

Member Name: _____   Member ID #: _____

Address: _____   Phone: _____

All workouts must occur within a six-month period.

	DATE	EXERCISE AND FACILITY	INSTRUCTOR INITIAL		DATE	EXERCISE AND FACILITY	INSTRUCTOR INITIAL
1				26			
2				27			
3				28			
4				29			
5				30			
6				31			
7				32			
8				33			
9				34			
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25				50			