UnitedHealthcare
Sweat Equity Program

Reimbursement Form

Please Print

Member Information			
Member First Name:	Member Last Name:	Date of Birth (Month/Day/Year):	Gender:
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:		Health Plan ID Number:	Group Number:
Street Address:			
City:		State:	ZIP Code:

Six-Month Period Sweat Equity Program	
Start Date:	End Date:

Completing and Submitting This Form

1. **Use one form per subscriber/subscriber's covered spouse/domestic partner. Record the 50 fitness facility visits and/or classes that you went to in a six-month period on the chart shown below. Record only one session per day.**
   - The first date you put on the chart is the beginning of your six-month program.
   - Your program will end six months from this date. Do not make entries for activity after your program end date.
   - If you complete 50 qualifying workouts in less than six months, please do not submit your reimbursement request early. We cannot accept reimbursement requests before six months have passed.
   - Instead of filling in the dates of your 50 workouts, you can attach to this form one of the following documents:
     - A computer printout of your visits to the fitness facility and/or classes completed, including dates and the name of the place.
     - Receipts that show the dates of your fitness facility visits and/or classes, with the name of the place.

   Your documentation must include signatures from a facility representative or class administrator to prove the use.
2. **Attach 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, during the six-month period.[1]
3. **Enclose a copy of the brochure or flier** that describes the cardio equipment at the facility you used or the cardio benefits of the class or organized group fitness event in which you participated.
4. **Mail documentation to:**
   UnitedHealthcare Sweat Equity Reimbursement Program
   P.O. Box 740806
   Atlanta, GA 30374

These documents must be mailed to us (postmarked) no later than 180 days from your program end date. **Requests postmarked after this date won't be reimbursed.**

Questions? Please call us at the toll-free phone number on your health plan ID card.

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Fitness Events, Facility Visits and Classes (Record only one session per day.)									
Date (mm/dd/yyyy)	Session Type*	Date (mm/dd/yyyy)	Session Type*	Date (mm/dd/yyyy)	Session Type*	Date (mm/dd/yyyy)	Session Type*	Date (mm/dd/yyyy)	Session Type*
1. (six-month start date)	F/C	13.	F/C	25.	F/C	37.	F/C	44.	F/C
2.	F/C	14.	F/C	26.	F/C	38.	F/C	45.	F/C
3.	F/C	15.	F/C	27.	F/C	39.	F/C	46.	F/C
4.	F/C	16.	F/C	28.	F/C	40.	F/C	47.	F/C
5.	F/C	17.	F/C	29.	F/C	41.	F/C	48.	F/C
6.	F/C	18.	F/C	30.	F/C	42.	F/C	49.	F/C
7.	F/C	19.	F/C	31.	F/C	43.	F/C	50 (six-month end date)	F/C
8.	F/C	20.	F/C	32.	F/C	**FOR INTERNAL USE ONLY:** TIN: 0-69000001 Provider: Sweat Equity Dx: Z71.9 HCPC: S9970 POS: OL		Maximum Reimbursement Value: $200 Subscriber, $100 Eligible Spouse	
9.	F/C	21.		33.					
10.	F/C	22.		34.					
11.	F/C	23.		35.					
12.	F/C	24.		36.					

Fitness Event, Class, Session, Facility Information

Organization name: _____ Organization name (if a 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 Center/Instructor Information

Facility employee/Class instructor name: _____

Signature: _____ Date: _____

Instructor or other facility employee's signature above shows that the instructor/facility encourages 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.[2]

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 of Sweat Equity member: _____ Date: _____

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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 or the subscriber's covered spouse or domestic partner; no other dependents are eligible. For the subscriber's spouse or domestic partner to be eligible for this benefit, he or she must also be enrolled in a UnitedHealthcare product. The program may not be available to all UnitedHealthcare plan subscribers and their spouses or partners. Reimbursement is generally limited to the lesser of $200 (subscriber)/$100 (covered spouse/partner) or the actual amount of the qualifying fitness costs per six-month period, but the reimbursement may vary by plan. Refer to your Certificate of Coverage, Summary Plan Description or other governing member document to determine eligibility, including your plan's benefit and for application deadlines.
- To be eligible for reimbursement under the program, the qualifying facility, class or organized group physical 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.
- You must be an active employee at the time of your application for reimbursement. We will reimburse only those qualified visits, sessions or events that were completed while you were a UnitedHealthcare member. We will not reimburse visits or sessions 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 six-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 loss 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 six-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 six-month period for which you made a full-year's payment providing you have met the requirements for another, consecutive reimbursement.
- Complete one form per member, for each six-month period for which you are applying for reimbursement.
- We cannot accept requests for reimbursement before your six-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, incorrect or cannot be substantiated, the application for reimbursement will be delayed or denied.
- 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.

*Indicate "F" for Facility/Gym; "C" for Class including organized group event (e.g., marathon).

[1] 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.

[2] If any fraudulent activity is detected (e.g., misrepresented physical activity), you may be suspended and/or terminated from the program. In New York, 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.

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.

(UHC NY SG (1-100) eff 010118, upon renewal; UHC NY LG (100+) and UHC NJ LG (51+) eff 070118, upon renewal)

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