Wellness Benefit Reimbursement

Weekly Scheduled Hours: ☐1-19 $15 ☐20-29 $25 ☐30+ $35

Employee name: _____ Reimbursement amount: _____

Membership start date: _____ Membership end date: _____

My membership is paid: ☐Annually ☐Monthly ☐Other or type of membership: _____

Membership Information

Center name: _____ Telephone number: _____

Address: _____ City, State, ZIP: _____

I certify that the request complies with the wellness benefit reimbursement policy. Please attach receipt each month for membership purchase.

Signature: _____ Date: _____