



Wellness Benefit Reimbursement

Weekly Scheduled Hours:	1-19	20-29	30+
	\$15	\$25	\$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: _____