Blue Cross Blue Shield of Rhode Island | BROWNHealth UNIVERSITY

Get well and get money back

You want to be healthy. You want to be well. And we want to help you do that.

Brown University Health is giving you up to **$150 back** on your costs for an activity tracker, a gym membership, exercise classes, the purchase of instructional videos and exercise equipment.

1. Purchase an activity tracker, home exercise equipment, or on-demand exercise classes, or sign up for yoga, kickboxing, a fitness class, or gym membership.

2. Save your itemized receipts. When you reach $150, submit the "Well-being Reimbursement Request" and all receipts to BCBSRI.

3. Get well and get your reimbursement!

Need some fitness gear? Activity tracker? Shoes?

Head over to **Blue365deals.com** to see how much you can save with offers from 45 national brands, from Fitbit® to Reebok®. Just for being a Blue Cross member.

Always consult a physician before beginning any new exercise program.

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Blue Cross Blue Shield of Rhode Island

WELL-BEING REIMBURSEMENT REQUEST

PLEASE PRINT ALL INFORMATION CLEARLY

This well-being reimbursement applies one time per family, per calendar year. All well-being reimbursement requests must be submitted by March 31 of the following year. Reimbursement will be paid to the active Brown University Health employee/subscriber.

BROWN UNIVERSITY HEALTH EMPLOYEE/SUBSCRIBER INFORMATION (POLICYHOLDER)

Brown University Health Employee ID Number **OR** Subscriber ID Number

Employee/Subscriber's Last Name	First Name	M.I.	Date of Birth
			_____/_____/_____

Address - Number and Street	City	State	Zip Code

WELL-BEING ITEM DETAILS

Total Dollars Requested: $_____ Calendar Year_____

Home exercise equipment or gear: $_____Other: $_____

☐ Membership Fees: $_____ ☐ Fitness Class Fees: $_____ ☐ Activity Tracker: $_____

Valid proof of payment must be attached. Acceptable forms are: itemized receipt for activity tracker, itemized receipt from fitness club or group exercise facility, a credit card statement indicating fitness club or exercise payment, or a letter on letterhead with an authorized signature indicating dates, line items, and payment amount.

CERTIFICATION (This form must be signed and dated below.)

I certify that the information provided in support of this submission is complete and accurate and that I have not previously submitted for these services. I understand that this reimbursement may be considered taxable income. I also understand that Blue Cross & Blue Shield of Rhode Island may request any additional information it deems necessary to verify that services were received and payment was made.

Subscriber or
Member's Signature:_____ Date:_____/_____/_____

COMPLETE THIS FORM AND MAIL IT TO:

BCBSRI Claims Department
500 Exchange Street
Providence, RI 02903-2699

If you have questions about the program or this form, please call the **Brown University Health Employee CARE Center** at (401) 429-2102 or 1-866-987-3706. The CARE Center hours are **Monday – Friday, 8:00 a.m. – 8:00 p.m.,** and **Saturday, 8:00 a.m. – noon.**

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