Blue Cross Blue Shield of Rhode Island | Lifespan Delivering health with care®

GET ACTIVE AND GET MONEY BACK

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

Lifespan is giving you up to **$150 back** on your costs for a gym membership or exercise classes.

1. Head to your neighborhood gym. Or sign up for yoga, kickboxing, or another fitness class.
2. Save your receipts. When you reach $150, send them to us with the form on the other side of this sheet.
3. Get active 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.

Form on back of page>

Blue Cross Blue Shield of Rhode Island

FITNESS REIMBURSEMENT REQUEST

PLEASE PRINT ALL INFORMATION CLEARLY

This fitness reimbursement applies one time per family, per calendar year. All fitness reimbursement requests must be submitted by March 31 of the following year. Reimbursement will be paid to the active Lifespan employee/subscriber.

SUBSCRIBER INFORMATION (POLICYHOLDER)

Member Identification Number on Subscriber ID Card	Subscriber's Last Name	**First Name**	M.I.

Address - Number and Street	City	State	Zip Code

REIMBURSEMENT INFORMATION

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

Fitness Program Name	City	State	Zip Code

Total dollars requested: $_____for:_____ Calendar Year_____

☐ Membership fees: $_____ ☐ Fitness Class fees: $_____

Valid proof of payment must be attached. Acceptable forms are: 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 **Lifespan 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.**