

**Physical Well-Being Benefit
 Direct Reimbursement Form**

Smoke Cessation Weight Loss Golf Club Swim Club Martial Arts

Member's Name _____

Member's Address _____

Member's S.S. No. _____

Company & Store No. _____

Phone No. _____

I have attended and completed a course in _____ from _____
Course Name Date

to _____ at _____
Date Name of Facility

I hereby certify that the foregoing information is true and correct to the best of my knowledge, information and belief. I further certify that I am subject to punishment for making false statements under 18 PA C.S.A. 4904

Member's Signature _____ Date _____

Provider Name _____

Provider Tax ID No. _____

Provider's Address _____

Provider's Phone No. _____

Fee for Course _____

_____ has attended and completed a course in _____
Member's Name Course Name

from _____ to _____ at _____
Date Date Name of Facility

Program Director _____ Date _____

*****Member, please see instructions on back*****

Member Instructions:

1. This Reimbursement Form must be completed by both you and the provider.
2. After completion of form, it should be sent to the Fund office accompanied by the following:
 - a. A legible copy of Provider Agreement (contract)
 - b. Legible copy of receipts (check, Visa, etc.)
3. Send all of the above to:

**UFCW Local 1776 and Participating Employers Health and Welfare Fund
3031 B Walton Road
Plymouth Meeting, PA 19462**