# HEALTH CLUB MEMBERSHIP ACKNOWLEDGEMENT FORM FOR 2020

## Eligible Employees Who Have Elected Medical Coverage

#### **REQUIREMENTS:**

- Employee and eligible spouse (if applicable) must be enrolled in Highmark Blue Shield medical coverage and employed by the County for the entire 2020 calendar year.
- Employee can be reimbursed up to a total of **\$280.00** per calendar year (including spouse) for membership in fullservice gyms and/or instructor lead classes whose primary business is a fitness center. Reimbursement for a pair of athletic shoes not exceed \$50.
- Employee will be eligible for reimbursement by providing the following:
  - o 2020 Health Club Membership (Acknowledgement Form below)
  - o Athletic shoes \$50 each; must have a gym membership.
- Request for reimbursement may only be submitted once per calendar year and during the year the costs are incurred.
- Employee must provide proof of <u>2020 membership at a health club</u>. Documentation of proof of membership must be current and include the following information:
  - ✓ Letter/printout from Health Club, dated not earlier than November 2020, on their letterhead showing the employee's name, amount paid and membership dates; OR
  - ✓ Tivity Fitness Your Way Members can print their payment activity from the Tivity Site. Directions available on the County intranet.
- Deadline to submit is **Friday**, **December 4**, **2020** (If documents are not signed or the required documentation is not attached, employee will not be reimbursed).

Submit Reimbursement Form and receipts to the Benefits Box: LC-FitnessReimbursement@lehighcounty.org

#### Your gym key fob is NOT proof of membership.

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### (EMPLOYEE/SPOUSE)

□ I hereby acknowledge that I/we am/are enrolled in a one-year membership at the health club named below, and I have <u>attached documentation verifying my yearly membership</u>.

Amount to be reimbursed: \_\_\_\_\_

Additionally, in 2020 I purchased Athletic shoes for myself and/or my spouse. I have <u>attached receipt(s) documenting the purchase</u>.

Amount to be reimbursed: \_\_\_\_\_

Name of Health Club (Please Print)

Employee's Name (Please Print)

Employee's Signature

Date

Employee # / Location

EMPLOYEE/ELIGIBLE SPOUSE (IF APPLICABLE) MUST BE COVERED UNDER COUNTY OF LEHIGH MEDICAL BENEFITS TO BE ELIGIBLE FOR THE HEALTH CLUB FACILITY/GYM SHOE REIMBURSEMENT