

**WCA GROUP HEALTH TRUST
HEALTH CLUB REIMBURSEMENT FORM**



Employer		Group Number	76-
Employee Name		UMR Member ID Number	
Dependent Name <i>(family membership only)</i>			
Fitness Center:			

Reimbursement Amount Requested <i>(check one):</i>	Claim Submission Checklist <i>(all items must be legible):</i>
<input type="checkbox"/> Single Membership <input type="checkbox"/> Family Membership	<input type="checkbox"/> Itemized Receipt Showing Single or Family Membership (no contracts please) <input type="checkbox"/> Proof of payment receipt <i>(check one)</i> - <input type="checkbox"/> Cash <input type="checkbox"/> Check <input type="checkbox"/> Credit <input type="checkbox"/> Debit
Services that do not require payment or are paid through gift cards/certificates are not reimbursable through your Health Plan.	

Submit a copy of your itemized statement, receipt and proof of payment along with this completed claim form via:

Fax: 855-405-2189
 Email: ghthealthclubsubmissions@umr.com
 Mail: UMR
 PO BOX 8033
 WAUSAU WI 54402-8033

Register and log into **www.umr.com** to view your claim details. Please allow 2-3 weeks for processing.

If you need assistance with the claim form or have questions on submitted, processed or denied claims, please contact UMR Customer Service at the number listed on the back of your ID card.

This incentive program is available to every employee/retiree and their spouse that is covered by the WCA Group Health Trust medical plan as of the date of this form. *Your information will remain confidential and will not be shared with your employer or any other third party.*

**If insufficient documentation is received, the claim will not be processed or will be denied.
 Balance Due statements are not valid claims.**