Oxford® Sweat Equity Program
Reimbursement Form

Please Print

Member name: _____ Street address: _____

Date of birth: _____City, State, ZIP code: _____

Oxford member ID number: _____

Six-month period program start date: _____ Six-month period program end date: _____

Completing and Submitting This Form

1. **Record the 50 fitness facility visits and/or classes that you went to in a six-month period on the chart shown below. (Record only one session per day.)**
   - The first date you put on the chart is the beginning of your six-month program period.
   - The last date you put on the chart should be on or before the last date of the six-month period that you are asking for reimbursement. Do not include any facility visits or classes after this date.

Note: Instead of filling in the dates of your 50 workouts, you can attach to this form one of the following documents:

- A computer printout of your visits to the fitness facility and/or classes completed, including dates and the name of the place.
- Receipts that show the dates of your fitness facility visits and/or classes, with the name of the place.

Your documentation must include signatures from a facility representative or class administrator to prove the use.

2. **Attach proof of payment** (e.g., receipt, payroll deduction, automatic bank withdrawal statement) for the fitness facility fee, as well as any money you paid for fitness classes, during the six-month period.[1]
3. **Enclose a copy of the brochure or flier** that describes the cardio equipment at the facility you used or the cardio benefits of the class you took.
4. **Mail documentation to:**
   Oxford Sweat Equity Reimbursement Program
   P.O. Box 29130
   Hot Springs, AR 71903

Note: These documents must be mailed to us (postmarked) no later than 180 days from the last date of the six-month period that you are asking to be reimbursed. **Requests postmarked after this date won't be reimbursed.**

5. **Questions?** Please call us at the toll-free phone number ("For Members") on the back of your health plan ID card.

Fitness Facility Visits and Classes (Record only one session per day.)

Date (mm/dd/yyyy)	Session Type*	Date (mm/dd/yyyy)	Session Type*	Date (mm/dd/yyyy)	Session Type*
1. (six-month start date)	F/C	18.	F/C	35.	F/C
2.	F/C	19.	F/C	36.	F/C
3.	F/C	20.	F/C	37.	F/C
4.	F/C	21.	F/C	38.	F/C
5.	F/C	22.	F/C	39.	F/C
6.	F/C	23.	F/C	40.	F/C
7.	F/C	24.	F/C	41.	F/C
8.	F/C	25.	F/C	42.	F/C
9.	F/C	26.	F/C	43.	F/C
10.	F/C	27.	F/C	44.	F/C
11.	F/C	28.	F/C	45.	F/C
12.	F/C	29.	F/C	46.	F/C
13.	F/C	30.	F/C	47.	F/C
14.	F/C	31.	F/C	48.	F/C
15.	F/C	32.	F/C	49.	F/C
16.	F/C	33.	F/C	50. (six-month end date)	F/C
17.	F/C	34.	F/C		

*Indicate "**F**" for Facility/Gym; "**C**" for Class.

[1] On your proof of payment, please be sure to cross out any personal account ID information that's not needed so it isn't readable.

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Fitness Facility Information

Facility name: _____

Facility type: _____

Address: _____

City, State, ZIP code: _____

Telephone number: _____

Facility name (if a second facility was used): _____

Facility type: _____

Address: _____

City, State, ZIP code: _____

Telephone number: _____

Fitness Class/Session Information

Names of class(es)/session(s): _____

_____

_____

Fitness Center/Instructor Information

Facility employee/Class instructor name: _____

Signature: _____ Date: _____

Instructor or other facility employee's signature above shows that the instructor/facility encourages cardio wellness for members.

Member Verification

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. In New York, any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

My signature below confirms that all of the information I have provided on this form and attached is full, complete and true to the best of my knowledge.False statements will result in the denial of reimbursement.

Signature of Sweat Equity member: _____ Date: _____

Exclusions and Limitations

- Participation in this program is completely voluntary and at the discretion of the member and his or her physician.
- For this program, the use of "you" and "member" in communications refers to the Oxford plan subscriber or the subscriber's covered spouse or domestic partner; no other covered dependents are eligible. The program is not available to all Oxford plan subscribers and their spouses or partners, including those affiliated with any Connecticut plan and some New York and New Jersey plans.
- Refer to your Certificate of Coverage, Summary Plan Description or other governing member document to determine eligibility for this reimbursement, confirm your plan's benefit and for application deadlines.
- To be eligible for reimbursement under the program, the qualifying facility or classes that you choose must be available to the general public and promote cardiovascular wellness, as determined by us, and have staff supervision.
- You must be an active employee at the time of your application for reimbursement. We will reimburse only those qualified visits or sessions that were completed while you were a member of the Oxford plan. We will not reimburse visits that occurred before your coverage became effective or after your coverage terminates. Partial reimbursements will not be given for fewer than 50 workouts in a six-month period.
- You must hold an active fitness facility or class membership for the facility/class named in the request at the time of your application for reimbursement.
- Memberships in tennis clubs, country clubs, social clubs, sports teams, weight loss clinics or spas or any other similar organizations, leagues or facilities will not be reimbursed. We will not reimburse you for the purchase of lessons, equipment, clothing, vitamins or other items or services that may be offered by the facility. Reimbursement is limited to actual workout visits. Physical and rehabilitative therapies do not apply.
- Lifetime memberships are not eligible for reimbursement.
- If you paid for a full-year's facility membership or class enrollment in advance, at the end of the first six-month period for which you are applying for reimbursement, submit the receipt along with the required documentation noted above for reimbursement against half of the annual fee that you paid. Repeat this process at the end of your second six-month period for which you made a full-year's payment providing you have met the requirements for another, consecutive reimbursement.
- Complete one form per member, for each six-month period for which you are applying for reimbursement.
- If any information is missing from this form, incorrect or cannot be substantiated, the application for reimbursement will be delayed or denied.
- Any information we collect in conjunction with this program is kept confidential according to HIPAA requirements and is separate from and has no effect on a member's medical benefits or premium.

You should consult with an appropriate tax professional to determine if you have any tax obligations from receiving reimbursement under this program. Use one form per subscriber/subscriber's covered spouse/domestic partner.

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