WELLNESS CLAIM

HAWAII LABORERS' HEALTH AND WELFARE TRUST FUND

ATTENTION: CLAIMS DEPARTMENT
1440 Kapiolani Blvd., Suite 800 - Honolulu, Hawaii 96814
Phone: Oahu - (808) 441-8600; Neighbor Islands Dial Direct 1 (888) 520-8078; Fax: (808) 441-8750

NOTE: PLEASE SUBMIT ONE CLAIM FORM PER COVERED INDIVIDUAL AND MAIL TO THE ADDRESS ABOVE.
PLEASE COMPLETE ALL APPLICABLE SECTION(S) FOR WHICH YOU ARE SEEKING REIMBURSEMENT.

Part I - THIS SECTION IS FOR MEMBER INFORMATION ONLY PLEASE PRINT

LAST NAME	FIRST	MIDDLE	SOCIAL SECURITY NUMBER	PHONE #
			- -	

STREET ADDRESS OR P.O. BOX	CITY	STATE	ZIP CODE

COMPLETE THIS SECTION IF CLAIM IS FOR SPOUSE OR DEPENDENT

SPOUSE/DEPENDENT NAME	RELATIONSHIP TO MEMBER	SPOUSE/DEPENDENT SS #
	☐ SPOUSE ☐ DEPENDENT	- -

I HEREBY CERTIFY THAT THE INFORMATION CONTAINED HEREON IS TRUE AND CORRECT

MEMBER'S SIGNATURE X DATE SIGNED / / 20

Part II - FITNESS CENTER CLAIM: PLEASE ATTACH PROOF OF PAYMENT/RECEIPTS TO THIS CLAIM FORM.

MONTH/YEAR	MEMBERSHIP FEE PAID	MONTH/YEAR	MEMBERSHIP FEE PAID	MONTH/YEAR	MEMBERSHIP FEE PAID
JAN. 20 ____	$	MAY 20 ____	$	SEPT. 20 ____	$
FEB. 20 ____	$	JUNE 20 ____	$	OCT. 20 ____	$
MARCH 20 ____	$	JULY 20 ____	$	NOV. 20 ____	$
APRIL 20 ____	$	AUG. 20 ____	$	DEC. 20 ____	$

NAME OF FITNESS CENTER	FITNESS CENTER PHONE NUMBER

Part III - SMOKING CLINIC CLAIM: PLEASE ATTACH PROOF OF PAYMENT/RECEIPTS TO THIS CLAIM FORM.

NAME OF PROGRAM	TAX ID NO.	PROGRAM START DATE	PROGRAM END DATE	# OF SESSIONS IN ATTENDANCE
				____ OF ____

I CERTIFY THAT THE CLAIMANT NAMED ABOVE HAS COMPLETED A SMOKING CESSATION PROGRAM

PROGRAM REPRESENTATIVE - PRINT NAME	SIGNATURE	DATE	REPRESENTATIVE PHONE #
	X		

Part IV - WEIGHT WATCHERS: PLEASE ATTACH PROOF OF PAYMENT/RECEIPTS TO THIS CLAIM FORM. THIS BENEFIT IS FOR MEMBER AND/OR SPOUSE ONLY.

PROVIDER	TAX ID NO.	PROGRAM START DATE	PROGRAM END DATE	# OF SESSIONS IN ATTENDANCE
WEIGHT WATCHERS	**30-0230678**			

I CERTIFY THAT THE CLAIMANT NAMED ABOVE HAS COMPLETED A 10-WEEK PROGRAM WITH WEIGHT WATCHERS

PROGRAM REPRESENTATIVE - PRINT NAME	SIGNATURE	DATE	OAHU SITE PHONE #
	X		**487-3373**

REV. 10/18

CLAIMS MUST BE FILED WITHIN:

- Ninety (90) days from the last day of the month for which you are seeking a fitness center reimbursement (Part II)
- Ninety (90) days from the program end date or completion of a smoking cessation and/or 10-week Weight Watchers program (Part III & IV)

RETURN TO ADDRESS ABOVE

Completing A Wellness Claim
Helpful Tips

- **Submit one (1) claim per person and complete each applicable section entirely.**
  You may use the same claim form for reimbursement of multiple benefits per person.
  For example: If you are seeking reimbursement for smoking cessation classes and for fitness center monthly fees, you must complete Part I, Part II and Part III on the claim and submit it along with any applicable receipts. Your spouse may do the same but on a separate claim form.

- **Part I – General Information**
  - This section must be completed by the member/subscriber.
  - If the claim is for your spouse or dependent child, be sure to complete the section that requests for their information.
  - Don't forget to sign and date the bottom of this section.

- **Part II – Fitness Center**
  - For Self-Insured and Kaiser (Grandfathered) Members only.
  - Complete only the sections that apply to the month(s) for which you are seeking reimbursement.
  - Reimbursement is up to $21 per month and will not exceed the amount that you paid.
  - Be sure to submit copies of receipts and/or proof of payment for the month(s) that you are requesting reimbursement.
  - We will only reimburse for the months for which you are eligible. Therefore, although we are able to reimburse for retrospective or current months, we will NOT be able to reimburse for prospective months.
  - If you have a Fitness Center contract that covers multiple months for which you paid a lump sum payment, you must submit a copy of your contract along with your claim, which should indicate the period of the contract and the lump sum payment made.

    For example: If you purchased a Fitness Center membership for 1 year beginning Feb 1, 2009 through January 31, 2010 for a total of $240 (which equates to $20 per month), a copy of the contract must be submitted with your claim for reimbursement so we know which month(s) to reimburse for and how much. In this case, the amount reimbursed per eligible month is $20.

  - You must submit a claim for reimbursement within ninety (90) days form the last day of the month for which you are requesting reimbursement. For example: If I am requesting reimbursement for May 2008, our office must receive a claim no later than August 31, 2008.

- **Part III – Smoking Clinics**
  - Reimbursement is up to $80/session and will not exceed the amount that you paid.
  - This section is for reimbursement of Smoking Cessation Clinics/Classes ONLY. Refer to your benefits on how to obtain reimbursement for Smoking Cessation Prescription Drugs, Devices & Agents.
  - You must submit a claim for reimbursement within ninety (90) days from the 'program end date'.
  - No reimbursement will be made without attached proof of payment/receipts and a signature from the program representative certifying that you completed the session of classes.

- **Part IV – Weight Watchers**
  - The benefit is for members and spouses only.
  - You must submit a claim for reimbursement within ninety (90) days from the 'program end date'.
  - No reimbursement will be made without a signature form the program representative certifying that you completed a 10-week program.

Submit Claims To: Hawaii Laborers' Health & Welfare Trust Fund
Attn: Claims Department
1440 Kapiolani Blvd., Suite 800
Honolulu, HI 96814

For Questions Call: (808) 441-8700 or (888) 520-8078 toll free for neighbor islands.