



## Gym Membership Reimbursement Tracking Form

Health Republic Insurance of New York

P.O. Box 6329

Syracuse, NY 13217-6329

Member Services: (888) 990-5702 | Fax: (315) 432-9442

Getting motivated to go to the gym is a little bit easier now that Health Republic Insurance of New York (HRINY) gives you a reimbursement towards your gym membership.

### How does it work?

As an HRINY subscriber, all you have to do is go to the gym 50 times in a consecutive six-month period to be eligible for up to a \$200 reimbursement on your gym membership. In addition, if your spouse or domestic partner also is covered on your HRINY plan, he/she can receive up to \$100 if he/she also uses the gym 50 times in a consecutive six month period. Gym visits must occur during active HRINY coverage. Reimbursement will be processed within 30 days and mailed to your address on record.

### Process to Receive Reimbursement:

- ☐ Completely fill out both sides of this form.
- ☐ Submit a copy of your current gym bill showing the membership fee paid for the dates of use under consideration.
- ☐ Submit one of the following: 1) Complete the tracking form on page two. A gym facility representative must sign and date the reimbursement form after each visit to the gym.  
OR 2) Request an official printout from the exercise facility, which specifies the number of visits and the dates of each visit. It must be signed by a facility representative.

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### COMPLETE INFORMATION BELOW

Submit one form per member. Please print.

#### → SUBSCRIBER INFORMATION:

Name (Last, First, Middle Initial): \_\_\_\_\_

HRINY Member ID#

|  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|
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|--|--|--|--|--|--|--|--|--|--|

#### → SPOUSE/DOMESTIC PARTNER INFORMATION:

Name (Last, First, Middle Initial): \_\_\_\_\_

Calendar/Membership Year: 201\_\_\_\_\_

Name of Gym Facility where you are an active member: \_\_\_\_\_

Address of Facility (Street/City/State/Zip): \_\_\_\_\_

Telephone: \_\_\_\_\_ Gym Facility Representative Name (please print) \_\_\_\_\_

Gym Facility Representative Signature \_\_\_\_\_ Date: \_\_\_\_\_

### YOUR SIGNATURE REQUIRED

I \_\_\_\_\_ (HRINY Member) attest that the above information is true and accurate, and the services were received and paid for as detailed in the bill information provided here from my exercise facility/(ies) named. I acknowledge that if any information on this form is misleading or fraudulent, it will result in the denial of my reimbursement. I also understand that Health Republic Insurance of New York may request any additional information it deems necessary to verify that services were received and payment was made. I understand that the gym membership reimbursement may be considered taxable income.

Member Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Para recibir información en Español por el correo, por favor llame al 888-990-5702*



**Required: Track Your 50 Gym Visit Dates & Signatures from Gym Staff**

| Date of Visit | Signature of Facility Representative | Date of Visit | Signature of Facility Representative | Date of Visit | Signature of Facility Representative |
|---------------|--------------------------------------|---------------|--------------------------------------|---------------|--------------------------------------|
| 1.            |                                      | 18.           |                                      | 35.           |                                      |
| 2.            |                                      | 19.           |                                      | 36.           |                                      |
| 3.            |                                      | 20.           |                                      | 37.           |                                      |
| 4.            |                                      | 21.           |                                      | 38.           |                                      |
| 5.            |                                      | 22.           |                                      | 39.           |                                      |
| 6.            |                                      | 23.           |                                      | 40.           |                                      |
| 7.            |                                      | 24.           |                                      | 41.           |                                      |
| 8.            |                                      | 25.           |                                      | 42.           |                                      |
| 9.            |                                      | 26.           |                                      | 43.           |                                      |
| 10.           |                                      | 27.           |                                      | 44.           |                                      |
| 11.           |                                      | 28.           |                                      | 45.           |                                      |
| 12.           |                                      | 29.           |                                      | 46.           |                                      |
| 13.           |                                      | 30.           |                                      | 47.           |                                      |
| 14.           |                                      | 31.           |                                      | 48.           |                                      |
| 15.           |                                      | 32.           |                                      | 49.           |                                      |
| 16.           |                                      | 33.           |                                      | 50.           |                                      |
| 17.           |                                      | 34.           |                                      |               |                                      |

**Please submit this form and all documentation to:**

Health Republic Insurance of New York | P.O. Box 6329 | Syracuse, NY 13217-6329

OR Fax to: (315) 432-9442

**FOR INTERNAL USE ONLY:**

|                 |  |
|-----------------|--|
| CPT CODE: S9970 |  |
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