



PHYSICAL FITNESS BENEFIT CLAIM FORM

EMPLOYEE NAME: _____ **SS#:** _____

MAILING ADDRESS: _____

GOAL: Work out just 10 times each month, and you'll receive \$150.00 after completing six consecutive months. You'll receive your second \$150.00 after completing another six months. Please have an authorized official from your health club or exercise program sign your participation sheet.

MONTH: _____

	DATE	ACTIVITY	SIGNATURE
1)	_____	_____	_____
2)	_____	_____	_____
3)	_____	_____	_____
4)	_____	_____	_____
5)	_____	_____	_____
6)	_____	_____	_____
7)	_____	_____	_____
8)	_____	_____	_____
9)	_____	_____	_____
10)	_____	_____	_____

Wellness Seminar Attended: _____

Seminar Sponsor: _____

Date Started: ____/____/____

Date Completed: ____/____/____

Cost (Attached Receipts): \$ _____

(Employee/Dependent Signature and Date)