



FITNESS REWARDS

Healthy Members are Happy Members

We know that staying with an exercise routine isn't always easy. To encourage you to get fit and stay healthy, your AffinityAccess Plan provides partial reimbursement to the Subscriber and the Subscriber's Covered Spouse for exercise facility fees or membership fees. It's simple! Once you are a member of an AffinityAccess Plan, you (the Subscriber and/or the Subscriber's Covered Spouse) are eligible for the partial reimbursement. Check your subscriber contract under the Wellness Benefits section for more specific information about this reimbursement program.

FIRST SELECT A GYM. The fitness center must maintain equipment and programs that promote cardiovascular wellness (memberships in tennis clubs, country clubs, weight loss clinics, spas or any other similar facilities are not eligible). You must be an **active** member AND complete **50 visits in a six-month period per plan year** to qualify for reimbursement.

OBTAIN A FORM. Contact the AffinityAccess Member Service line at 888.543.6973 to get your reimbursement form.

TRACK YOUR VISITS. Each time you visit the exercise facility, a facility representative must sign and date the reimbursement form. As a substitute for filling in the dates of your 50 gym visits on this form, you may submit one of the pieces of information below as an attachment to this form.

- a. A computer printout of your visits to the fitness center, with a signature from a gym representative
- b. Receipts that indicate each time you have visited the gym, with a signature from a gym representative

SUBMIT YOUR FORM. At the end of the six-month period, you can mail or fax the completed reimbursement form and supporting documents to :

Mail: Affinity Health Plan
Attention: Member Services
QHP Fitness Rewards
1776 Eastchester Road
Bronx, NY 10461

Fax: 718.536.3386

*Please complete the form in its entirety or the processing of your reimbursement may be delayed or denied.

HOW MUCH CAN YOU GET REIMBURSED? Once Affinity Health Plan receives and accepts the completed reimbursement form, the Subscriber will be reimbursed a maximum of \$200 and/or the Subscriber's covered Spouse will be reimbursed a maximum of \$100 per six-month period, per plan year.



FITNESS REWARDS FORM

Subscriber Name: _____ Covered Spouse Name: _____

Subscriber ID Number: _____ Covered Spouse ID Number: _____

Subscriber Date of Birth: _____ Covered Spouse Date of Birth: _____

Six Month Period Requested: Start Date: _____ End Date: _____

DATES OF 50 GYM VISITS

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