TEACHERS HEALTH TRUST
FOR TEACHERS BY TEACHERS

Health Improvement Benefit Reimbursement Form

Please complete the following information and return this form and an ***itemized*** receipt to UMR Benefit Plan Management at the address below. The Health Improvement Benefit will pay up to $50 per calendar year. You have exactly six months from date of service to submit your claim for reimbursement. Thank you!

Date of Reimbursement Request: _____

Participant Name: _____ UMR Member ID #: _____

Address: _____

Phone Number: _____ Date of Birth: _____

Please Check One Box

☐ I am a CCSD educator enrolled as a subscriber on the health plan

☐ I am a CCSD educator enrolled as a dependent spouse on the health plan

Type of Reimbursement (check one):

☐ Health Club Membership Fees/Dues ☐ Personal Training Fees

☐ Tobacco Prevention Fees ☐ Weight Management Support Group Fees

Name of Provider: _____

Amount Paid: _____

_____ _____

Signature Date

Remit form and ***itemized*** receipt to:

UMR
P.O. Box 8033
Wausau, WI 54402-8033