TEACHERS
HEALTH TRUST

Health Improvement Benefit Reimbursement Form

Please complete the following information and return this form and an ***itemized*** receipt to Allegiance Benefit Plan Management at the address below. You have exactly six months from date of service to submit your claim for reimbursement. Thank you!

Date of Reimbursement Request: _____

Participant Name:_____ Allegiance 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 (circle 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:
Allegiance Benefit Plan Management
PO Box 3018
Missoula, MT 59806