Health Improvement Benefit Reimbursement Form

Please complete the following information and return this form and an ***itemized*** receipt to the Trust offices 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: ______________________ Trust ID #: __________

Address: ______________________________

Phone Number: __________________ Date of Birth: ______________

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

For Internal Use Only:

Received by: ______________________ **Date:** __________

Date Check Request Submitted: ______________________