

**Wellness Incentive Form**

**Reimbursement Offer# 818**

The City of Seattle is providing a wellness incentive for benefits-eligible employees and their spouse/domestic partner/dependents (age 18 or older) participating in the Weight Watchers program.

**Complete this form and follow the instructions below to receive reimbursement.**

**1.** Weight Watchers participant, fill out the following required information:

|  |  |  |  |
| --- | --- | --- | --- |
| Your Name: |  | Employee ID |  |
| Relationship to Employee | [ ] Self [ ] Spouse [ ] Domestic Partner [ ] Dependent (18 or older) |
| Employee Address: | *Address where the reimbursement check is to be mailed* |
| City |  | State |  | Zip |  |
| Email address: |  | Phone |  |

**2.** *To receive reimbursement you must be a Weight Watchers member for a minimum of 3 months*

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| --- |
| I certify that I attended at least 10 Weight Watchers meetings in a rolling 90-day period and am eligible for a $30 reimbursement. The date of the last meeting I attended within this period was \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Participants Signature Meeting Name / Location Number Date  |

**3.** Obtain and attach you Doctor’s note. The following completed sentence must be on a signed physician’s prescription pad or letterhead: “I prescribe Weight Watchers meeting attendance for [Participant Name] treatment of the following medical condition: [specify medical condition, e.g. obesity, hypertension, heart disease].

**4**. Meetings Members - Weight Watchers Leader/Receptionist signature required to verify your attendance:

|  |
| --- |
| I certify that this Member has attended the minimum number of meetings indicated above. |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Weight Watchers Leader/Receptionist Signature Meeting Name / Location Number  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date |

**5**. Submit this complete form doctor’s note to the address below.

 The envelope or email must be postmarked within 90 days

 of the date shown in section 2 above.

**By providing the information above and submitting this wellness incentive form, you acknowledge and agree to the following Terms and Conditions:** *Request form must be fully completed.*  ***Keep copies of all material submitted.***  *Weight Watchers is not responsible for lost, late or misdirected mail. Wellness incentive checks are ordinarily processed within 30 days of receipt. All rights to any earned wellness incentives are voided upon your separation from employment. Void where prohibited or restricted by law. Availability and terms of reimbursement may change without notice. To track reimbursement log onto: www.checkyourrebate.com/**cityofseattle*

 **Email:** WeightWatchersRebates@callTSC.com

 **Or Mail:**

 Weight Watchers Reimbursement Center

 Offer # 818

 PO Box 800195

 Houston, TX 77280-9970