



WELLNESS CLAIM

HAWAII LABORERS' HEALTH AND WELFARE TRUST FUND

ATTENTION: CLAIMS DEPARTMENT

1440 Kapiolani Blvd., Suite 800 - Honolulu, Hawaii 96814

Phone: Oahu - (808) 441-8600; Neighbor Islands Dial Direct 1 (888) 520-8078; Fax: (808) 441-8750

NOTE: PLEASE SUBMIT ONE CLAIM FORM PER COVERED INDIVIDUAL AND MAIL TO THE ADDRESS ABOVE.
PLEASE COMPLETE ALL APPLICABLE SECTION(S) FOR WHICH YOU ARE SEEKING REIMBURSEMENT.

Part I - THIS SECTION IS FOR MEMBER INFORMATION ONLY PLEASE PRINT				
LAST NAME	FIRST	MIDDLE	SOCIAL SECURITY NUMBER	PHONE #
STREET ADDRESS OR P.O. BOX		CITY	STATE	ZIP CODE
COMPLETE THIS SECTION IF CLAIM IS FOR SPOUSE OR DEPENDENT				
SPOUSE/DEPENDENT NAME		RELATIONSHIP TO MEMBER <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT	SPOUSE/DEPENDENT SS #	
I HEREBY CERTIFY THAT THE INFORMATION CONTAINED HEREON IS TRUE AND CORRECT				
MEMBER'S SIGNATURE X			DATE SIGNED / / 20	

Part II - FITNESS CENTER CLAIM: PLEASE ATTACH PROOF OF PAYMENT/RECEIPTS TO THIS CLAIM FORM.					
MONTH/YEAR	MEMBERSHIP FEE PAID	MONTH/YEAR	MEMBERSHIP FEE PAID	MONTH/YEAR	MEMBERSHIP FEE PAID
JAN. 20 _____	\$ _____	MAY 20 _____	\$ _____	SEPT. 20 _____	\$ _____
FEB. 20 _____	\$ _____	JUNE 20 _____	\$ _____	OCT. 20 _____	\$ _____
MARCH 20 _____	\$ _____	JULY 20 _____	\$ _____	NOV. 20 _____	\$ _____
APRIL 20 _____	\$ _____	AUG. 20 _____	\$ _____	DEC. 20 _____	\$ _____
NAME OF FITNESS CENTER				FITNESS CENTER PHONE NUMBER	

Part III - SMOKING CLINIC CLAIM: PLEASE ATTACH PROOF OF PAYMENT/RECEIPTS TO THIS CLAIM FORM.					
NAME OF PROGRAM	TAX ID NO.	PROGRAM START DATE	PROGRAM END DATE	# OF SESSIONS IN ATTENDANCE _____ OF _____	
I CERTIFY THAT THE CLAIMANT NAMED ABOVE HAS COMPLETED A SMOKING CESSATION PROGRAM					
PROGRAM REPRESENTATIVE - PRINT NAME		SIGNATURE X		DATE	REPRESENTATIVE PHONE #

Part IV - WEIGHT WATCHERS: PLEASE ATTACH PROOF OF PAYMENT/RECEIPTS TO THIS CLAIM FORM. THIS BENEFIT IS FOR MEMBER AND/OR SPOUSE ONLY.					
PROVIDER WEIGHT WATCHERS	TAX ID NO. 30-0230678	PROGRAM START DATE	PROGRAM END DATE	# OF SESSIONS IN ATTENDANCE	
I CERTIFY THAT THE CLAIMANT NAMED ABOVE HAS COMPLETED A 10-WEEK PROGRAM WITH WEIGHT WATCHERS					
PROGRAM REPRESENTATIVE - PRINT NAME		SIGNATURE X		DATE	OAHU SITE PHONE # 487-3373

CLAIMS MUST BE FILED WITHIN:

- One (1) year from the last day of the month for which you are seeking a fitness center reimbursement (Part II)
- Ninety (90) days from the program end date or completion of a smoking cessation and/or 10-week Weight Watchers program (Part III & IV)

RETURN TO ADDRESS ABOVE

Completing A Wellness Claim Helpful Tips

- **Submit one (1) claim per person.**
- **Fill in each applicable section completely.**
- **You may use the same claim form for reimbursement of multiple benefits per person.**
For example: If you are seeking reimbursement for smoking cessation classes and for fitness center monthly fees, you must complete Part I, Part II and Part III on the claim and submit it along with any applicable receipts. Your spouse may do the same but on a separate claim form.
- **Part I – General Information**
 - This section must be completed by the member/subscriber.
 - If the claim is for your spouse or dependent child, be sure to complete the section that requests for their information.
 - Remember to sign and date the bottom of this section.
- **Part II – Fitness Center**
 - Complete only the sections that apply to the month(s) for which you are seeking reimbursement.
 - Reimbursement is up to \$21 per month and will not exceed the amount that you paid.
 - Be sure to submit copies of receipts and/or proof of payment for the month(s) that you are requesting reimbursement.
 - We will only reimburse for months for which you are eligible. Therefore, although we are able to reimburse for retro or current months, we will NOT be able to reimburse for prospective months.
 - You must submit a claim for reimbursement within one (1) year from the last day of the month for which you are requesting reimbursement. For example: If you are requesting reimbursement for May 2008, our office must receive a claim no later than May 31, 2009.
- **Part III – Smoking Clinics**
 - Reimbursement is up to \$80 per session and will not exceed the amount that you paid.
 - This section is for reimbursement of Smoking Cessation Clinics/Classes ONLY. Refer to your benefits on how to obtain reimbursement for Smoking Cessation Prescription Drugs, Devices & Agents.
 - You must submit a claim for reimbursement within ninety (90) days from the 'program end date'.
 - No reimbursement will be made without attached proof of payment/receipts and a signature from the program representative certifying that you completed the session of classes.
- **Part IV – Weight Watchers**
 - This benefit is for members and spouses only.
 - You must submit a claim for reimbursement within ninety (90) days from the 'program end date'.
 - No reimbursement will be made without a signature from the program representative certifying that you completed a 10-week program.

Submit Claims To: Hawaii Laborers' Health & Welfare Trust Fund
Attn: Claims Department
1440 Kapiolani Blvd., Suite 800
Honolulu, HI 96814

For Questions Call: (808) 441-8700 or (888) 520-8078 toll free for neighbor islands.