Fitness Benefit Form

DO NOT WRITE IN THIS SPACE
OFFICE USE ONLY

PLEASE PRINT ALL INFORMATION CLEARLY

SUBSCRIBER INFORMATION (Person in whose name coverage is held)

Identification Number (including alpha prefix)	Subscriber's Last Name	First Name	Middle Initial
Address–Number and Street	City	State	Zip Code
Employer's Name			

MEMBER INFORMATION

Member's Last Name	First Name	Middle Initial	Date of Birth: Mo. Day Yr.
Mailing Address (if different from subscriber's) Number and Street	City	State	Zip Code

Gender
- ❑ Male
- ❑ Female

Claimant is (check one):
- ❑ Subscriber (coverage holder)
- ❑ Spouse (of coverage holder)
- ❑ Child (age 19 or younger)
- ❑ Handicapped Dependent (age 19 or older)
- ❑ Student (age 19 or older)
- ❑ Stepchild
- ❑ Other (specify) _____

WHEN TO SUBMIT THIS FORM:
- After you have been a member of a health club and Blue Cross Blue Shield of Massachusetts for a full four months in a calendar year.
- Once per calendar year, filed by March 31 of the following year.

HEALTH CLUB INFORMATION REQUIRED:
Attach 8½" x 11" photocopies of dated, paid health club receipts, and your health club agreement/contract.

Name and Address of Health Club

TOTAL NUMBER OF RECEIPT COPIES ATTACHED: _____ TOTAL AMOUNT SUBMITTED: $ _____

CERTIFICATION AND AUTHORIZATION **(This form must be signed and dated below.)**

I authorize the release of any information to Blue Cross and Blue Shield of Massachusetts, Inc., about my health club membership. I certify that the information provided in support of this submission is complete and correct and that I have not previously submitted for these services.

Subscriber's/Member's Signature: _____ Date: _____

Please print, fold, and mail this form (including copies of paid receipts) to:
Blue Cross Blue Shield of Massachusetts
Local Claims Department
PO Box 986030
Boston, MA 02298

QUESTIONS?
To verify this benefit is within your plan or for further information, call the Member Service number on the front of your ID card.

MASSACHUSETTS

32-6980 (10/08) 25084