

# 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 / Year

Mailing Address (if different from subscriber's)  
Number and Street      City      State      Zip Code

Gender	Claimant is (check one):		
1. <input type="checkbox"/> Male	1. <input type="checkbox"/> Subscriber (coverage holder)	3. <input type="checkbox"/> Child (age 21 or younger)	
2. <input type="checkbox"/> Female	2. <input type="checkbox"/> Spouse (of coverage holder)	4. <input type="checkbox"/> Handicapped Dependent	

### WHEN TO SUBMIT THIS FORM:

- **After** you have been a member of a health club and Dental Blue Healthy Supplement for at least 4 months in a calendar year.
- **Once per calendar year, filed by March 31 of the following year.**

### HEALTH CLUB INFORMATION REQUIRED

(Attach 8.5" x 11" photocopies of dated, paid health club receipts and your health club agreement/contract.)

#### Name and Address of Health Club

### Questions?

For further information, call us at **1-800-433-7766**.

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 tear off, fold, and mail this form (including copies of paid receipts) to:**

Blue Cross Blue Shield of Massachusetts  
Federal Employee Program Claims Department  
PO Box 55380  
Boston, MA 02205-8338