activerewards
live healthier and save money

$300 ActiveRewards reimbursement

Now you can be reimbursed up to $300 for programs or services that help you get and stay healthy.

what it covers

- Health Club Memberships - Single or family friendly membership fees for facilities open to the public and, at a minimum, provide both cardio and strength training equipment.
- Children's Fitness Activities - Community based fitness classes, physical activities and organized sports for children through age 18. Examples include soccer, baseball, bowling leagues, sports camps, swim programs, dance lessons, gymnastics classes and karate classes.
- Weight Management Programs - Including Jenny Craig and Weight Watchers
- Individual Adult Classes and Lessons - Including aerobic, yoga & Tai Chi classes, exercise programs, dance lessons & personal training services.

what does not qualify?

- Lasik eye surgery
- Merchandise such as attire, fitness equipment, videos, publications, golf clubs, bicycles, and entry fees
- Teeth whitening strips or over the counter whitening products
- Motorcycle classes or courses
- Drivers Education

how to use it

You choose your provider, pay for services, and submit the reimbursement form on the back of this sheet along with a receipt. Univera Healthcare will reimburse you directly.

how to submit your reimbursement form

1. Copies of all bills and/or receipts for reimbursement must be enclosed with this completed ActiveRewards reimbursement form with the following information included:
   - Name of person providing service
   - Dates of service
   - Description of service
   - Amount charged
   - Name of person receiving service

   Balance bills, canceled checks, etc., are not acceptable.
2. Reimbursement forms must be submitted within 12 months of receiving services to be considered for payment by Univera Healthcare.
3. Reimbursement forms must be signed by the member.
4. Mail completed forms with bills and/or receipts to:

   Univera Healthcare
   PO Box 211256
   Eagan, MN 55121

If you have any questions, please call our Customer Service Department at the number on the back of your identification card.

univera HEALTHCARE
an excellus company

PLEASE REVIEW AND LEGIBLY COMPLETE ALL SECTIONS (1-4) OF THIS FORM

Please Note- *If you do not have all of the required information please contact the provider of service for assistance prior to submitting your claim. Failure to supply all of the required information may result in delayed processing and/or subsequent return or denial of your claim submission.*

If your address has changed or is incorrect, please call our Customer Service Department at the telephone numbers listed on your identification card.

ActiveRewards
Reimbursement Form

Mail completed form and all required information to :

Univera Healthcare
P.O. Box 211256
Eagan, NY 55121

SECTION 1
INFORMATION REQUIRED FOR REIMBURSEMENT

COPIES OF ALL BILLS/RECEIPTS FOR QUALIFIED EXPENSES **MUST BE SUBMITTED** WITH THIS FORM IN ORDER FOR REIMBURSEMENT TO BE CONSIDERED. BALANCE BILL, CANCELLED CHECKS ETC. ARE **NOT** ACCEPTABLE. BILLS MUST ***CLEARLY*** INDICATE **ALL OF THE FOLLOWING**:

1-FULL NAME AND DATE OF BIRTH OF MEMBER RECEIVING SERVICES

2-NAME AND ADDRESS OF THE INDIVIDUAL OR BUSINESS/ORGANIZATION PROVIDING THE SERVICE(S)

3-DATE FOR **EACH** SERVICE RENDERED

4-DESCRIPTION AND/OR VALID PROCEDURE CODE FOR **EACH** SERVICE RENDERED

5-CHARGE FOR **EACH** SERVICE RENDERED

6-ALL CLAIMS FOR REIMBURSEMENT MUST BE SUBMITTED WITHIN 12 MONTHS FROM THE DATE SERVICES WERE RENDERED IN ORDER TO BE CONSIDERED FOR PAYMENT.

SECTION 2
SUBSCRIBER INFORMATION *Please enter all information exactly as shown on your ID card*

SUBSCRIBER'S LAST NAME	SUBSCRIBER'S FIRST NAME	INITIAL	SUBSCRIBER IDENTIFICATION NUMBER

ADDRESS-NUMBER AND STREET	CITY	STATE	ZIP CODE

SECTION 3
SERVICE INFORMATION *Please complete all sections below for each individual service rendered*

MEMBER'S FULL NAME	MEMBER'S DATE OF BIRTH	RELATIONSHIP TO SUBSCRIBER	DATE(S) OF SERVICE	SERVICE INFORMATION	AMOUNT
LAST NAME: ____ FIRST NAME: ____	___/___/____ mm dd yyyy	☐ SELF ☐ SPOUSE ☐ CHILD	FROM: __/__/__ TO: __/__/__	☐ HEALTH RELATED CLASSES FOR ADULTS *S9451/Dx. V65.41* ☐ WEIGHT MANAGEMENT PROGRAMS *S9449/Dx. V65.41* ☐ HEALTH CLUB/GYM MEMBERSHIP *S9446/Dx. V65.41* ☐ CHILDREN'S FITNESS ACTIVITIES *S9451/Dx. V65.41* PROVIDED BY:____	$____
LAST NAME: ____ FIRST NAME: ____	___/___/____ mm dd yyyy	☐ SELF ☐ SPOUSE ☐ CHILD	FROM: __/__/__ TO: __/__/__	☐ HEALTH RELATED CLASSES FOR ADULTS *S9451/Dx. V65.41* ☐ WEIGHT MANAGEMENT PROGRAMS *S9449/Dx. V65.41* ☐ HEALTH CLUB/GYM MEMBERSHIP *S9446/Dx. V65.41* ☐ CHILDREN'S FITNESS ACTIVITIES *S9451/Dx. V65.41* PROVIDED BY:____	$____
LAST NAME: ____ FIRST NAME: ____	___/___/____ mm dd yyyy	☐ SELF ☐ SPOUSE ☐ CHILD	FROM: __/__/__ TO: __/__/__	☐ HEALTH RELATED CLASSES FOR ADULTS *S9451/Dx. V65.41* ☐ WEIGHT MANAGEMENT PROGRAMS *S9449/Dx. V65.41* ☐ HEALTH CLUB/GYM MEMBERSHIP *S9446/Dx. V65.41* ☐ CHILDREN'S FITNESS ACTIVITIES *S9451/Dx. V65.41* PROVIDED BY:____	$____

SECTION 4
SIGNATURE AND DATE *Unsigned forms will be returned*

I CERTIFY THAT THE INFORMATION SUBMITTED IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. THE EXPENSES INCURRED WERE FOR MYSELF, SPOUSE, OR QUALIFIED DEPENDENT(S), AND THAT THESE EXPENSES ARE NOT REIMBURSABLE UNDER ANY OTHER HEALTH PLAN COVERAGE.

SUBSCRIBER SIGNATURE: ____________________ **DATE:** __________

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals information concerning any fact material thereto, for the purpose of misleading, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of each violation.