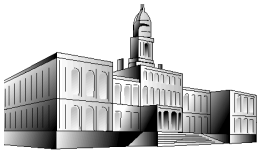
Management Benefits Fund (MBF)

Health and Fitness Reimbursement Program Claim Form

- PLEASE PRINT -



I. MBF MEMBER INFORMATION:

SOCIAL SECURITY #:	AGENCY NAME:		
LAST NAME:	FIRST NAME:	M.I.:	
ADDRESS:	CITY:	STATE:	ZIP CODE:
EMAIL ADDRESS:			
WORK TELEPHONE NUMBER:	HOME TELEPHONE NUMBER:		

II. DIRECT DEPOSIT AVAILABLE FOR RETIREES AND UNIFIED COURT SYSTEM (UCS) EMPLOYEES.

ALL ACTIVE EMPLOYEES ARE REIMBURSED THROUGH THEIR REGULAR PAYCHECK.

ACCOUNT TYPE: (CHECK ONLY ONE)	PERSONS NAMED ON ACCOUNT: (PRINT EXACTLY - INCLUDE TRUSTEE OR JOINT OWNER)	ABA NUMBER*
❑ SAVINGS ❑ CHECKING	PERSON 1:_____ PERSON 2:_____	ACCOUNT NUMBER**

***ABA BANK NUMBER:** CHECKING ACCOUNTS - THE ABA NUMBER IS THE FIRST NINE (9) NUMBERS PRIOR TO THE ACCOUNT NUMBER AT THE BOTTOM LEFT CORNER OF THE CHECK. SAVINGS ACCOUNTS - CONTACT YOUR BANK FOR THE ABA NUMBER, IF NOT KNOWN. ****ACCOUNT NUMBER:** SEE CHECK, PASSBOOK, OR ACCOUNT STATEMENT FOR ACCOUNT NUMBER.

III. CLAIM PERIODS -

You can submit up to four claims, each for a 6-month period, on this form. Each claim must be for a period of 6 months and cannot exceed two years from the end date of the claim submission, e.g. begin date 02/01/2023, end date 07/31/2023. Please note that only the MBF member and MBF member's spouse/domestic partner are eligible for this benefit. Other dependents are not eligible for this benefit. Each claim must include a proof of payment for the entire claim period.

BEGIN DATE: MM / DD / YYYY END DATE: MM / DD / YYYY ❑ SELF ❑ SPOUSE/DOMESTIC PARTNER

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IV. SIGNATURE -

If you are unable to sign the form or import your electronic signature, the form will be accepted by typing your name in the signature field.

By signing this form, the claimant hereby acknowledes that MBF has not given any medical advice nor has recommended participation in this benefit.* The claimant certifies that he or she has no current medical condition that would prohibit participation in an exercise program. The claimant further acknowledges that MBF bears no liability resulting from any injuries or damages arising from use of this benefit. The claimant hereby certifies that he or she has participated in a fitness program for six consecutive months. The claimant understands that the dollar value of this benefit will be included as taxable income to the MBF member.

The claimant hereby authorizes MBF to deposit his or her Health and Fitness reimbursement directly into his or her checking or savings account as requested, if applicable. The claimant also grants authorization for the reversal of a credit to the account in the event the credit was made in error. The claimant understands that, under the "National Automated Clearing House Association" operating guidelines and rules, MBF can only reverse the amount of the incorrect direct deposit. The claimant must provide direct deposit information for each claim submitted.

MEMBER'S SIGNATURE:_____ DATE: MM / DD / YYYY

Required

SPOUSE'S/DOMESTIC PARTNER'S SIGNATURE:_____ DATE: MM / DD / YYYY

Spouse's/domestic partner's claim cannot be processed without member's signature.

**** Prior to participating in this benefit, the Management Benefits Fund recommends that you consult with your own physician.***

V. HEALTH CLUB/FITNESS FACILITY AND MEMBERSHIP INFORMATION: *(Please print.)*

FACILITY NAME(S):

DATE CURRENT MEMBERSHIP PURCHASED: MM / DD / YYYY TYPE OF MEMBERSHIP PURCHASED: ❑ INDIVIDUAL ❑ FAMILY**

MEMBERSHIP PAYMENT FREQUENCY: ❑ MONTHLY: $_____ ❑ SEMI-ANNUALLY: $_____

❑ ANNUALLY: $_____ ❑ OTHER: $_____

***** If your membership is a family contract, this payment will be prorated.***

This should be submitted electronically to:https://nyc-mbf.leapfile.net

Please see the reverse side for Claim Filing Guidelines. ⟶

- CLAIM FILING GUIDELINES -

1. The MBF member and/or spouse/domestic partner must complete this form.
2. You are eligible for reimbursement after completing six consecutive months of regular exercise at an MBF approved health club.
3. Effective March 1, 2024, after each 6-month period, you will be reimbursed up to a maximum of $500.00. This benefit will be included in taxable income to the MBF member in the year in which it is received. Note: If the member's or spouse/domestic partner's claim period includes dates both prior to and after March 1, 2024, then the reimbursement will be a maximum reimbursement of $500 for the 6-month claim period.
4. You can submit up to four claims, each for a 6-month period, on this form. Each claim must be for a period of 6 months and cannot exceed two years from the end date of the claim submission, e.g. begin date 02/01/2023, end date 07/31/2023. Please note that only the MBF member and MBF member's spouse/domestic partner are eligible for this benefit. Other dependents are not eligible for this benefit. Each claim must include a proof of payment for the entire claim period.
5. MBF reserves the right to request additional documentation and/or deny any claims.