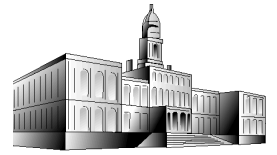




Management Benefits Fund (MBF)

Health and Fitness Reimbursement Program Claim Form

- PLEASE PRINT -



I. CHECK ONE: (A separate form must be completed for each claimant.)

MBF MEMBER MBF MEMBER SPOUSE/DOMESTIC PARTNER

II. 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: - -		

III. SPOUSE/DOMESTIC PARTNER INFORMATION: (To be completed only if claimant is MBF member's spouse/domestic partner)

LAST NAME:		FIRST NAME:		M.I.:
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IV. DIRECT DEPOSIT VIA PERSONAL ACCOUNT INFORMATION: (Only available to employees of the Unified Court System and retired members) All active employees will be reimbursed through their regular paycheck.

ACCOUNT TYPE: (CHECK ONLY ONE)	PERSONS NAMED ON ACCOUNT: (PRINT EXACTLY - INCLUDE TRUSTEE OR JOINT OWNER)	ABA NUMBER*
<input type="checkbox"/> SAVINGS	PERSON 1: _____	ACCOUNT NUMBER**
<input type="checkbox"/> CHECKING	PERSON 2: _____	

*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.

V. CLAIM PERIOD (Please indicate a six (6) month claim period only.)

BEGIN DATE: MM / DD / YYYY END DATE: MM / DD / YYYY (End date must not exceed two (2) years from date of claim submission.)

VI. 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 acknowledges 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: ____/____/____
Required

SPOUSE'S/DOMESTIC PARTNER'S SIGNATURE: _____ DATE: ____/____/____
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.**

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

FACILITY NAME:		NAME OF FACILITY MANAGER		
ADDRESS:		CITY:	STATE:	ZIP CODE:
TELEPHONE NUMBER:				

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

TYPE OF MEMBERSHIP PURCHASED***:
 MONTHLY: \$ _____ SEMI-ANNUALLY: \$ _____
 ANNUALLY: \$ _____ BIENNIAL: \$ _____ TRIENNIAL: \$ _____

**** If your membership is a family contract, this payment will be prorated. *** Please attach a payment receipt or contract from health club.**

VIII. PROGRAM VALIDATION: (To be signed by Facility Manager) 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.

I hereby certify that the facility described above has a fitness program and that the member attended the facility for six consecutive months.

FACILITY MANAGER'S SIGNATURE: _____ DATE: ____/____/____

- CLAIM FILING GUIDELINES -

1. The MBF member and/or spouse/domestic partner and the facility manager from your fitness facility 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. After each six-month period, you will be reimbursed up to a maximum of \$250.00. This benefit will be included in taxable income to the MBF member in the year in which it is received. Claim forms are available through the MBF web site at nyc.gov/mbf or by calling (212) 306-7290. Outside NYC call toll-free at (888) 4000-MBF (623). Please mail completed claim form to: Management Benefits Fund, Bowling Green Station, P.O. Box 707, New York, NY 10274
4. You must complete a separate claim form for each consecutive six-month exercise period and attach a copy of the payment receipt. 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.
5. MBF reserves the right to request additional documentation and/or deny any claims.