WCA GROUP HEALTH TRUST
HEALTH CLUB REIMBURSEMENT FORM

Employer		**Group Number**	76-
Employee Name		**UMR Member ID Number**	
Dependent Name *(family membership only)*			
Fitness Center:			

Reimbursement Amount Requested *(check one):* ☐ Single Membership ☐ Family Membership	**Claim Submission Checklist** *(all items must be legible)*: ☐ Itemized Receipt Showing Single or Family Membership (no contracts please) ☐ Proof of payment receipt *(check one)* - ☐ Cash ☐ Check ☐ Credit ☐ Debit

Services that do not require payment or are paid through gift cards/certificates are not reimbursable through your Health Plan.

Submit a copy of your itemized statement, receipt and proof of payment along with this completed claim form via:

Fax: 855-405-2189

Email: ghthealthclubsubmissions@umr.com

Mail: UMR
PO BOX 8033
WAUSAU WI 54402-8033

Register and log into **www.umr.com** to view your claim details. Please allow 2-3 weeks for processing.

If you need assistance with the claim form or have questions on submitted, processed or denied claims, please contact UMR Customer Service at the number listed on the back of your ID card.

This incentive program is available to every employee/retiree and their spouse that is covered by the WCA Group Health Trust medical plan as of the date of this form. *Your information will remain confidential and will not be shared with your employer or any other third party.*

If insufficient documentation is received, the claim will not be processed or will be denied.
Balance Due statements are not valid claims.