0060

KAISER PERMANENTE®

Weight Watchers® **100% reimbursement form**

Eligibility

To be eligible for 100 percent reimbursement of the program fees, you must:

1) Meet the Weight Watchers® program eligibility requirements.

2) Be employed by Kaiser Foundation Health Plan of Washington or Kaiser Foundation Health Plan of Washington Options, Inc. (including temporary staff), *or* be a dependent, spouse, or domestic partner covered under a staff medical plan.

3) Discuss your participation with a member of your health care team to ensure that you meet the physical requirements and that he or she recommends your participation *before* beginning the program. Your care team member will need to confirm (on this form) that you have been diagnosed with diabetes or have a body-mass index (BMI) of 30 or above.

4) Have taken your annual health assessment during the current Wellness Works program year. (If you aren't covered under a staff medical plan, this isn't a requirement.)

Reimbursement instructions

1) Enroll in Weight Watchers. Choose either the Meetings or OnlinePlus membership.

2) No more than 30 days before starting the program, discuss with a member of your health care team whether you meet the physical requirements described under “Eligibility.” If so, ask that your BMI and weight be recorded in your medical record.

3) Apply for a 50 percent reimbursement after participating for 12 weeks. This must be sent in no later than 6 months after the date on proof of payment.

4) When you have reduced your weight by 5 percent, ask a member of your health care team to weigh you, record it in your medical record, and complete their portion of this form.

5) Send a copy of the completed form and proof of payment to the KP National HR Service Center:
Fax: 877-477-2329

Important information

- The reimbursement applies *only* to membership fees.
- Participants can continue to be reimbursed for membership fees as long as they maintain the original 5 percent weight loss. Maintenance of weight loss must be validated using this form every time reimbursement is requested.
- If it’s unreasonably difficult because of health to meet the conditions for the 100 percent reimbursement, or medically inadvisable for you to attempt to meet those conditions, we will work with you to create reasonable alternative requirements for you to qualify for the reimbursement. Call the HR Service Center, (877) 457-4772, for more information.
- Reimbursements for staff, dependents, spouses, and domestic partners will be provided via Payroll and reflected in the staff member's pay statement. Reimbursements are ordinarily processed within two pay periods of receipt of the completed form and proof of purchase.
- The first 50 percent of the discount, whether for you, dependents, spouse, or domestic partner, will be reported as wages on your pay advisory and W-2 statements. The reimbursement of the remaining 50 percent isn't taxable and will *not* be reported as wages on your W-2, except for reimbursements paid for non-dependent domestic partners or their children.
- The information you submit on this form will be treated as protected health information (PHI) under HIPAA.
- You must fully complete this form and attach proof of payment to get reimbursement.
- Availability and terms of reimbursement may change without notice.

Questions? Call the HR Service Center, (877) 457-4772.

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Staff member: Complete this section

1) Employee name: Click here to enter text.
2) Employee name: Click here to enter text.
3) Your work phone (123-456-7890): Click here to enter text.
4) Your work e-mail address: Click here to enter text.
5) Name of participant (if not you): Click here to enter text.
6) Offering for which you are requesting reimbursement: ☐Meetings ☐Online*Plus*
7) Date health care provider recommended participation in program: Click here to enter a date.
8) Time period for which you are requesting reimbursement: Click here to enter text.
(The first 50% portion must be submitted to Human Resources within 6 months of the transaction date on your proof of purchase. Please do not wait to submit this.)
9) Total amount for which you are requesting reimbursement: Click here to enter text.
10) Date you first started participating in Weight Watchers: Click here to enter a date.
11) Include a copy of your receipt with a detailed explanation of services. Circle the total paid for program fees.
12) I have completed my annual health assessment this year: ☐Yes ☐No
13) I'm covered by a staff medical plan: ☐Yes ☐No

By submitting this form for reimbursement, I affirm that the information I've provided is correct, and I acknowledge and agree to the program's terms and conditions as described on the form:

14) (If requesting for a family member) The participant named above is covered by a Kaiser Permanente staff medical plan: ☐Yes ☐No ☐Not applicable

Sign (in ink) _____ **Date** _____

Health care team member: Complete this section

Name of health care team member (print) _____

Title _____

Name of medical center or practice _____

By signing below, I am confirming that the participant named above:

1. Received a recommendation from his/her health care provider to participate in a weight management program at the date specified in item 7;

2. Was diagnosed with diabetes or had a body-mass index (BMI) of 30 or above on the date specified in item 7; *and*

3. Has experienced a weight reduction of 5 percent or more since receiving the recommendation described in paragraph 3 of the eligibility section, and has maintained a weight reduction of at least 5 percent since that time.

Sign (in ink) _____ **Date** _____

Print name _____