



# Weight Watchers® **50% reimbursement form**

## Eligibility

To be eligible for a 50 percent reimbursement of 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) Have a body-mass index (BMI) of 25 or above at the time of enrollment in the Weight Watchers program.
- 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 Online*Plus* membership.
- 2) After participating for 12 weeks, apply for a 50 percent rebate by filling out this form. Turn in the form within 6 months after the proof-of-payment date.
- 3) 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 monthly membership fees.
- You can get a 50 percent rebate for each 12 weeks of participation in Weight Watchers, as long as you still meet the eligibility requirements at the beginning of each 12-week period.
- If it's unreasonably difficult because of health to meet the conditions for the 50 percent reimbursement, or medically inadvisable for you to attempt to meet those conditions, we will work with you (and, if you wish, your health care provider) 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 and family members will be provided via Payroll. They are normally processed within two pay periods of receipt of completed form and proof of purchase. Reimbursements, whether for you or a family member, will be reported as wages on your pay advisory and W-2 statements.
- The information you submit on this form will be treated as protected health information under HIPAA.
- Reimbursement won't be processed unless both the form and proof of payment are received.
- Availability and terms of reimbursement may change without notice.

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

**Staff member: Complete this section (for self or participating family member)**

1) Employee name: [Click here to enter text.](#)

2) Employee ID: [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) Time period for which you are requesting reimbursement: [Click here to enter text.](#)

(Please note that the reimbursement request and the proof of purchase must be received by Human Resources within 6 months of the transaction date on your receipt or statement otherwise the transaction has expired and can't be reimbursed.)

8) Total amount for which you are requesting reimbursement: [Click here to enter text.](#)

9) Month, day, and year you first started participating in Weight Watchers: [Click here to enter a date.](#)

10) Include with this form a copy of your receipt or statement that shows the detailed explanation of services. Circle the total paid for the program fees.

11) I have completed my annual health assessment this year: ☐ Yes ☐ No

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

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:

**Sign** (in ink) \_\_\_\_\_

**Date** \_\_\_\_\_