Reimbursement Form for WW® Program

MEDICAL MUTUAL®

Note: This form should only be completed by Medical Mutual members who participated in their employers' Workshops in the Workplace program.

Complete a WW (formerly Weight Watchers) program and we will reimburse you part of your enrollment fees.

The amount you are reimbursed depends on completion of a 3- or 4-month program. Amounts include $50 for a 3-month program or $75 for a 4-month program. You can be reimbursed up to $150 each calendar year.

To be reimbursed, complete this form and attach proof of payment. Submit to Medical Mutual for processing. We will mail you a check within 60 days if approved.

We will return incomplete forms. All information will remain private.

Member Information

Name (First and Last)	Date of Birth	☐ Male ☐ Female
Address (Street)	ID Number (as it appears on your ID card)	
Address (City)	State	ZIP
Email Address	Phone Number	
Please verify the following: ☐ I completed a 3-month Workshops in the Workplace program; I completed a 4-month Workshops in the Workplace program	Program Start Date Program End Date	

Results for Current Series

During this program:

My starting weight was: _____ lbs My ending weight was: _____ lbs My height is: _____ feet _____ inches

I enrolled in this program to: ☐ Lose weight ☐ Maintain weight ☐ Improve wellness

See reverse for reimbursement requirements.

Reimbursement Requirements

Before submitting this form, please confirm you:

- Were an active Medical Mutual member at the start of the series through the time we receive the reimbursement form.
- Completed a 3-month or 4-month Workshops in the Workplace or Digital + Studio program.
- Filled out this form completely. This includes sharing your results with us. We will not accept incomplete forms.
- Had your WW workplace coach sign and validate the reimbursement form (see below), or submitted your weekly weight logs for a Digital program.
- Provided proof of payment with this form. Proof of payment could include:
  – WW receipt from your workplace coach
  – Canceled checks from your bank or financial institution
  – Copies of three or four consecutive credit/debit statements
  – Copies of three or four consecutive monthly passes
  – Printout of your WW account payment history

  Note: Include proof of payment made for you by your employer or any promotional discounts you received from WW, if applicable. The envelope must be postmarked within 90 days of your series end date.

Participant or Parent/Guardian Signature	Date

Submit Reimbursement Materials

Mail to: Medical Mutual
WW Program
MZ: 01-5B-7500
2060 East Ninth Street
Cleveland, OH 44115

Fax to: 1-888-219-8693

Email to: WeightWatchers@MedMutual.com

- You will receive your reimbursement check within 60 days after we receive your form.
- To print another form, log in to My Health Plan at MedMutual.com/member. Click Healthy Living then WW.
- If you have questions about your reimbursement, email us at WeightWatchers@MedMutual.com or call 1-800-251-2583.

To Be Completed by the WW Workplace Coach

Participant completed: ☐ 3-month Workshops in the Workplace program;
4-month Workshops in the Workplace program

The participant has completed the above-checked series. My signature verifies program completion.

Workplace Coach's Signature	Date
Workplace Coach's Name (Print)	Location Number