

# Weight Watchers at Work Reimbursement Form

## Get rewarded for losing weight!



\*Beginning Weight: \_\_\_\_\_

End Weight: \_\_\_\_\_

Attended Session From: \_\_\_\_\_ To: \_\_\_\_\_

Location(s) of meetings attended: \_\_\_\_\_

Series	Date	Leader initials attendance at end of meeting <i>(new requirement)</i>
Week 1	_____	_____
Week 2	_____	_____
Week 3	_____	_____
Week 4	_____	_____
Week 5	_____	_____
Week 6	_____	_____
Week 7	_____	_____
Week 8	_____	_____

To be eligible for the Weight Watchers at Work reimbursement, employees/dependents must be enrolled in a County-sponsored medical plan. Covered employees/dependents must attend the entire meeting for 7 out of 8 Weight Watchers meetings, and must have lost 3% of their beginning body weight by the end of the 8-week period. The first weigh-in and meeting are considered week one.

Participant Name: \_\_\_\_\_

Employee Name (Primary Insured): \_\_\_\_\_

Employee ID: 81 \_\_\_\_\_

Telephone: \_\_\_\_\_

E-mail: \_\_\_\_\_

**After completing the 8-week Weight Watchers session the following materials must be submitted to Wellness Works/Employee Benefits within 90 days:**

1. The Weight Watchers at Work Reimbursement Form
2. The Weight Watchers Weight Record (page with participant's name, barcode, and number)
3. Weight documentation (weekly attendance and weight log)

*\*Weight Watchers Online is not eligible for the reimbursement.*

After the information is verified, the incentive will be included in the employee's paycheck (timing depends on processing date.)

I hereby attest that I have fulfilled all the necessary requirements, as outlined above, to qualify me to receive the reimbursement for attending and successfully completing the Weight Watcher's at Work Program. I understand that falsifying information will result in either a denial or a revocation of my reimbursement. I declare that the above information is true and accurate to the best of my knowledge.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**All information should be delivered to Wellness Works/Employee Benefits:**

**Mail:** 301 W. Jefferson St., Suite 3200, Phoenix, AZ 85003

**Fax:** 602.506.2354 | **Email:** BenefitsService@mail.maricopa.gov