CWA/ IBEW 2213/ Verizon New York/New England Work and Family Committee

This is a Taxable Wellness Reimbursement Program

Complete ALL information

Your application **WILL NOT BE PROCESSED** if any information is missing. Please print clearly

Employee Name:		
Employee ID (found on paystub)	**Enterprise ID**(found on EWEB)	
Home Address:		
Street:		
City:	**State:**	**Zip Code:**
Home Phone:	**Cell Phone:**	
Email:		
Work Address:		
City:	**State:**	**Zip Code:**
Choose 1: ☐ **CWA Local**_____	☐ **IBEW 2213**	☐ **Management**
Type of Program: ☐ **Fitness**	☐ **Weight Management**	
Fitness or Weight Management Providers Name:		
Providers Tax ID Number:		
Providers Address:		
Providers Phone Number:		
Cost of membership:		
Type of payment: ☐**Annual**	☐ **Monthly** ☐ **Weekly** ☐ **Drop-in**	☐ **Other**
Membership is for: ☐ **Employee**	☐ **Employee/ Family**	**(family plan must be in employees name)**
Contract Effective Date:		
Contract Termination Date:		

You **MUST** attach a copy of the original contract and detailed receipts. Only **originals** applications will be accepted.

I, **(Print Name)**_____ ,request reimbursement for the eligible gym expenses listed above. My signature signifies I have read the criteria of the Health and Wellness/ Gym Membership Reimbursement Program and I agree to abide by them.

By signing and submitting application, I certify that the information that I have provided on this form is true and accurate. I further understand that suppling false information on this form may jeopardize my continued participation in the NY/NE Work & Family Fund

Employee Signature _____ Date: _____

Send original form and receipts to:

NY/NE Regional Work & Family Committee

c/o Beverly Steele, Fund Administrator

120 Hicksville Road, Room 200-A

Massapequa N.Y. 11758