

Fitness Benefit Form

PLEASE PRINT ALL INFORMATION CLEARLY

CIGNA Identification Number	Subscriber's Last Name	First Name	Middle Initial
Address - Number & Street		City	State
Zip Code			
Employer's Name Horizon Media, Inc.			
MEMBER INFORMATION <i>(Use a separate form for each member)</i>			
Member's Last Name	First Name	Middle Initial	Date of Birth
Sex 1. <input type="checkbox"/> Male 2. <input type="checkbox"/> Female	Claimant is (Check one) 1. <input type="checkbox"/> Subscriber 2. <input type="checkbox"/> Spouse	Employee Phone Number	Employee Email Address
WHEN TO SUBMIT THIS FORM: <ul style="list-style-type: none"> After you have been a member of CIGNA HealthCare for at least four months. Twice per calendar year: For benefit period July 1st thru December 31st, file by January 31st for reimbursement in February; for benefit period January 1st thru June 30th; file by July 31st for reimbursement in August. 			
CLUB/CLASS INFORMATION REQUIRED <i>(Attach itemized receipts and a copy of your health club contract)</i>			
Name and Address of Health Club	Benefit Year	Amount Charged	Office Use only

TOTAL NUMBER OF RECEIPTS ATTACHED: _____ TOTAL CHARGES: \$_____

Include all receipts for proof of payment & proof of 50 visits with this form. All Fitness Benefit payments will be sent to the Subscriber's address provided on this page.

CERTIFICATION AND AUTHORIZATION (This form must be signed and dated below)

I authorize the release of any information to CIGNA HealthCare, Inc. about my health club membership. I certify that the information provided in support of this submission is complete and correct and that I have not previously submitted for these services. I attest to the fact that I have completed a minimum of 50 visits to my health club/gym per 6 month period.

Subscriber's/Member's Signature: _____ Date: _____