



LAKESIDE INDUSTRIES WELLNESS PROGRAM Reimbursement Form



Lakeside Industries will provide reimbursement not to exceed \$600 per calendar year (January 1–Dec 31) for qualified employees. Covers participation in wellness related activities such as fitness club membership, weight loss programs (not including food), personal training, physical activity classes and sports teams that give you cardio/aerobic benefits such as soccer, swimming, yoga, etc. Maximum of \$100.00 reimbursement for equipment. New hires will receive a prorated reimbursement amount based on their hire date.

Employee Name:	
Employee #:	Division:

Payable Quarterly; To Receive Reimbursement:

1. All admin, non-union employees enrolled in the medical plan are eligible starting the 1st of the month following date of hire. Spouses not included.
2. Complete the online Health Advocate Personal Health Profile (PHP) & Tobacco Attestation.
3. Submit a copy of the facility's bill showing the cost.
4. Gym membership requires proof of a minimum of 6 visits per month or 18 quarterly. Provide a date log of your visits.
5. Submit this form along with payment receipts to Human Resources by the deadline each quarter. Must be turned in to HR no later than the dates below. Otherwise, the reimbursement will be processed the following quarter. (If one of these dates falls on a Saturday or Sunday, the due date is the following Monday.)

Deadline for Submission	Date reward distributed
April 7, July 7, Oct 7, Jan 7	Next available payroll date.

6. Reimbursement requests for expenses must be within the current benefit year.
7. Reimbursements will be taxed as a taxable fringe benefit per IRS regulations. You will see the amount that Lakeside pays for the reimbursement added to your taxable income under earnings description titled **Wellness** on your pay stub at the time you receive your reimbursement.

Submit:

1. This reimbursement form
2. Gym or class attendance records
3. Proof of payment or purchase

My signature below indicates that the information submitted in this request is true and accurate. I understand that falsification of information could result in the loss of the Wellness Program rewards in future months.

Amount requesting:

\$ _____ reimbursement (gym memberships, classes, etc.)
 +
 \$ _____ equipment (shoes, workout equipment, etc.)
 =
 \$ _____ **TOTAL AMOUNT REQUESTING FOR REIMBURSEMENT**

Signature: _____ Date: _____

For HR Use Only: Total Approved Reimbursement \$ _____ Notes: _____