

# Plumbers & Steamfitters Local 33

## Health & Welfare Fund

2501 Bell Avenue, Des Moines, IA 50321

Phone (515)243-3246, Fax (515)244-6606

### Fitness Membership, Health Class Prescription Form

#### PARTICIPANT INFORMATION

Participant Name:		ID Number:	
Patient Name:		Date of Birth:	
Address:	City:	State:	Zip:
Name & Address of Fitness Club:			
Type of Membership: Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> Other (explain) <input type="checkbox"/>			
Amount Requested for Reimbursement from HRA (proof of payment must be attached):			
Participant Signature:		Date:	

By signing above, I certify that my statements on this Claim Form are complete and true. I certify that this expense, reimbursed for myself, my spouse, or eligible dependents have not and will not be reimbursed under any other Health Reimbursement Account, insurance plan, nor be claimed as an income tax deduction.

#### PHYSICIAN'S PRESCRIPTION

Physician's Name (please print)	Physician's Address:	Phone Number:
Patient Name:		
Diagnosis:		
Duration of Treatment: Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> Other (explain) <input type="checkbox"/>		
Physician's Signature:		Date: