

GFit - Get Fit/Get Healthy Program Claim Form

Name _____ Employee # _____ Dept.# _____

List of Expenses

Please list below the amount you are requesting for reimbursement (maximum allowable reimbursement is \$35 per month). The program is for full-time employees only, with no reimbursement for expenses related to spouse or dependent activities.

Please attach detailed proof of expense – an itemized receipt, credit card statement or contract. **Proof must clearly show what qualified expense was purchased as well as the employee's name.**

Date(s) of Purchase	Expense Type	Amount Requested
Total Expenses \$		

Certification

I certify that the expenses listed above qualify for reimbursement and have been incurred by me. A detailed receipt has been included with this form as documentation of my expense.

Signature _____ Date _____

Please return to the Human Resources Division.

Reimbursements will only be processed quarterly. Claim forms and required documentation must be provided to Human Resources no later than:

- October 15 (July/August/September)**
- January 15 (October/November/December)**
- April 15 (January/February/March)**
- July 15 (April/May/June)**

No late submissions will be accepted, no exceptions.

FOR INTERNAL USE ONLY	
Amount Paid _____	FY _____