Healthy Benefits [redacted]

Healthy Eating & Weight Management

cis benefits
www.cisbenefits.org

Reimbursement Form

NAME*: _____

MAILING ADDRESS*: _____

DATE OF BIRTH*: _____

CIS EMPLOYER NAME*: _____

I certify that I am eligible to apply for program reimbursement as I am an active employee, retiree/COBRA, spouse/domestic partner, or dependent (18 and older) covered by a CIS medical plan.

_____ _____

Participant Signature* Date*

**Mandatory fields to receive reimbursement.*

Return by email to healthybenefits@cisoregon.org or fax to 503-763-3900

I am applying for reimbursement for the following program: (fill in 70% of the total program cost)

WW Community/At-Work Meeting Series/Amount: _____

Online WW - provide printout of one food log/weigh in per week: Amount: _____

Other Hospital/Community-Based Meeting Series/Amount: _____

You will be reimbursed 70% of the program cost up to a maximum of $400 for the 01/01/2019 - 12/31/2019 plan year if you meet the attendance requirements for the timeframe your request is for. Reimbursement requests for dates attended in the previous year, must be submitted by March 31 of the next year (e.g. - 12/31/18 meeting date must be requested by March 31, 2019.)

The Following Documents are REQUIRED to Process Your Reimbursement Request:

- ☐ Proof of payment
- ☐ Copy of your meeting attendance log indicating attendance at 70% or more of the meetings
- ☐ Complete the attached Outcomes Survey
- ☐ Copy of online points/food tracking record or weekly login (for online participants only)

CIS Processing Notes:

Reimbursement Amount $

Check Request Date:_____

Benefits Staff Name: _____

Please take a moment to complete this survey. **The completed survey is required for reimbursement and must be returned with your Reimbursement Form.** *Your answers are completely confidential and will be used only to evaluate the program.*

How helpful was this program in helping you lose weight or improve your health?

- ☐ Very helpful ☐ Somewhat helpful
- ☐ Helpful ☐ Not helpful
- ☐ Neutral

How helpful was this program in increasing your confidence to continue healthy changes on your own?

- ☐ Very helpful ☐ Somewhat helpful
- ☐ Helpful ☐ Not helpful
- ☐ Neutral

What changes have you noticed in your health since participating in this program? (Check all that apply.)

- ☐ No noticeable changes
- ☐ Feel more self-confident
- ☐ Improved clinical values (cholesterol, glucose, blood pressure)
- ☐ More productive
- ☐ Sleep better
- ☐ Weight loss
- ☐ More energy
- ☐ Improved dietary habits
- ☐ Other changes: _____

Are you more physically active in your life as a result of this program?

- ☐ Much more active ☐ Somewhat less active
- ☐ A little more active ☐ Other comments:_____
- ☐ About the same level of activity

If you didn't note any fitness, energy, or health improvement, what might be the reason?

- ☐ Program did not meet my needs
- ☐ Improvement will take more time
- ☐ No support for changes at home
- ☐ Other life issue kept me from making changes
- ☐ Other: ____

How important is physical activity to you now as compared to several months ago? Check all that apply.

- ☐ About the same importance as before
- ☐ More important than before
- ☐ Less important
- ☐ Other comments:_____

If weight loss was your goal, how do you feel you did? Please answer honestly, your answer is strictly confidential and does not affect your reimbursement.

Lost _____pounds

- ☐ Or, lost ___% of my beginning body weight
- ☐ Have lost _____pounds, and expect to reach my goal weight.
- ☐ Weight loss was not my goal

If this program has assisted you in improving your health or reaching a health goal, please describe what was most helpful.