Health LifeStyle Reimbursement Program
County of El Paso
Application for Reimbursement

Employee Name:_________________ Social Security#:________________

Address:________________________ City, State, Zip:___________________

Phone Number (Home):_______________ Phone Number (Work):________________

Location of
Facility:___________________________

Email Address:_____________________

Name of Exercise Facility:______________________

State Date of Wellness Program:___________________

The application for reimbursement is for the months of _____________ through____________

NOTICE: Employee must be a participant in the County Health Medical Plan to be eligible for the LifeStyle Reimbursement.

Application must be for: 6 or 12 consecutive months 8 visits per month. Eligible employees can receive reimbursement up to $90 for a consecutive 6 month period or up to $180 for a consecutive 12 month period

Attachments required for reimbursement:

1) Application for reimbursement 2) attendance record 3) proof of monthly payments 4) copy of fitness center application membership agreement, contract or renewal.

Employee Signature:__________________ Date:___________________

* Employees who are participating in payroll deduction will only need to provide Attendance records and application.

Revised 04/03/2015