Weight Loss Reimbursement Application

SARPY WELLNESS
Be Sarpy Strong!

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Instructions:

1. Employees must complete this form to obtain pre-approval prior to participation in program.
2. Submit completed form to Wellness Chairperson: wellnesschairperson@sarpy.com

EMPLOYEE INFORMATION

Name: _____

Department: _____

Job Title: _____

Email: _____ Phone #: _____

WEIGHT LOSS PROGRAM INFORMATION

Program / Company Name: _____

Start Date: _____ Start Weight: _____

EMPLOYEE ACKNOWLEDGMENTS

I acknowledge and understand that to be eligible for reimbursement, I must adhere to the following:

- This form must be completed and approved PRIOR to the start date listed above
- Lose five percent (5%) of my starting weight within twelve (12) weeks of the above start date
- Submit documentation from an authorized representative of the program and/or a licensed health care provider demonstrating the five percent (5%) weight loss
- Submit receipt(s) showing payment(s) for program
  (Receipts must be dated on or after submission of this form)
- Reimbursement is for costs incurred, up to $150.00

I understand any reimbursement will be made via the County Payroll System and is subject to taxation. I further acknowledge that this program may end at any time without further notice.

_____ _____
Employee Signature Date

PRE-APPROVAL

Wellness Committee Chair: ☐ Approve ☐ Deny Reason: _____

_____ _____
Signature Date

FINAL APPLICATION

Wellness Committee Chair: ☐ Approve ☐ Deny Reason: _____

_____ _____
Signature Date