



Slice of Life: Steps to Get Healthy

HEALTH AWARENESS PROGRAM GROUP REIMBURSEMENT FORM

New Hampshire Municipal Association
Workers' Compensation Trust
Property-Liability Trust
HealthTrust

New Hampshire Local Government Center
Slice of Life
PO Box 617 • Concord, NH 03302-0617

<p>PROGRAM INFORMATION</p> <p>Program Title: _____</p> <p>Provider/Instructor: _____</p> <p>Organization: _____</p> <p>Address: _____</p> <p>Date(s): _____</p> <p>Total Cost: _____</p> <p>Cost per participant: _____</p> <p>Please attach a class description and invoice.</p>
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<p>REIMBURSEMENT INFORMATION</p> <p>Please send check to the following (or indicate if members should be reimbursed directly):</p> <p>Group/Company Name: _____</p> <p>Address: _____</p> <p>_____</p> <p>Contact Name: _____</p> <p>Contact Phone: _____</p>
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PARTICIPANT CONSENT:

I consent that the cost of this presentation may be deducted from my \$300 per calendar year *Health Awareness Program* benefit. I understand that to be eligible for payment, I must have completed the GET HEALTHY *Personal Health Analysis Questionnaire*, I must attend at least 75 percent of the sessions and be insured through a LGC HealthTrust health plan. If I have depleted my \$300 annual benefit, I, or my employer, when so indicated, will be responsible for my portion of the cost of the program.

Name (please print)	Health Plan ID #
John Doe	123-45-6789
1.	
2.	
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12.	

Instructor Verification: I attest that the above-named individuals have attended at least 75 percent of the sessions for this program.

Instructor Signature

Date

Print Name

Phone Number