Physicians Plus Insurance Corporation Weight Watchers® Program Participation Validation Form

Member Name: _____ **Facilitator Name:**_____

Physicians Plus
Member Number: _____ **Program Location:** _____

Member Address: _____

In order to be eligible for reimbursement, you must either be enrolled in a community program at least 12 weeks in length and show proof of attendance at 10 out of 12 weekly meetings, OR be enrolled in an "At Work" program at least 10 weeks in length and show proof of attendance at 8 out of 10 weekly meetings, OR be enrolled in a traditional program and show proof of attending 10 meetings during a 12 week period. Lifetime memberships of Weight Watchers are not eligible for Good Health Bonus reimbursement.

Take this form to all meetings attended to have it signed by your facilitator to verify your participation.

Date	Facilitator Signature

Overall weight loss since starting the program: _____ Did you achieve your goal? _____

Please send this completed form to the following address for reimbursement:

Physicians Plus Insurance Corporation
Attn: Good Health Bonus
2650 Novation Parkway
Madison, WI 53713

OR, Fax to: (608) 327-0321

If you have any questions, call (608) 282-8900 or (800) 545-5015.

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