



New Hampshire Municipal Association
 Property-Liability Trust
 HealthTrust

Slice of Life: Steps to Get Healthy

HEALTH AWARENESS PROGRAM GROUP REIMBURSEMENT FORM

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

PROGRAM INFORMATION

Program Title: _____
 Provider/Instructor: _____
 Organization: _____
 Address: _____
 Date(s): _____
 Total Cost: _____
 Cost per participant: _____

Please attach a class description and invoice.

REIMBURSEMENT INFORMATION

Please send check to the following (or indicate if members should be reimbursed directly):

Group/Company
 Name: _____
 Address: _____

 Contact Name: _____
 Contact Phone: _____

PARTICIPANT CONSENT:

I consent that the cost of this presentation may be deducted from my Health Awareness Program benefit. I understand that to be eligible for payment, I must have completed the **onmyway™** Health Assessment, I must attend at least 75 percent of the sessions and be insured through a LGC HealthTrust health plan. If I have depleted my 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.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
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