

**BRICKLAYERS & ALLIED CRAFTWORKERS
LOCAL #2, ALBANY, NEW YORK, HEALTH BENEFIT FUND
300 CENTRE DRIVE
ALBANY, NY 12203
1-800-664-8314**



GYM MEMBERSHIP CLAIM FORM

Member Name: _____ SS# (last 4) _____

Address: _____

Gym Name: _____ Amount Requested: _____

Signature: _____

**Please take note of the following points regarding your
2021 gym membership reimbursement:**

- The Health Fund will reimburse (per family) up to \$125 annually for your paid gym membership. This does not get deducted from your HRA or WRA and is available to all eligible members, including opt-outs.
- You must show proof that the full \$125 has been paid or if your annual cost is less than \$125 you may claim that amount in December 2021.
- The reimbursement must be an actual gym such as: (YMCA, Planet Fitness, Golds Gym, ect...)
Personal home equipment does not qualify.
- The Fund is required to withhold tax from your reimbursement. If the Fund does not have a W-4 on file, the withholdings will be based on single/zero exemptions.

FOR OFFICE USE ONLY

| | | |
|-------------------|------------|------------------------|
| Approved by _____ | Date _____ | Amount Requested _____ |
| Reviewed by _____ | Date _____ | Amount Approved _____ |
| Amount Paid _____ | Date _____ | Amount Denied _____ |