



HEALTH CLUB/FITNESS EXPENSE BENEFIT APPLICATION - EXEMPT

Must print in Black or Blue ink ONLY.

| 1. Personal Information | | | |
|-------------------------|-----------------------|-----------------|-----|
| Employee ID | Last Name, First Name | Department | |
| Work Phone | | Home/Cell Phone | |
| Mailing Address | City | State | Zip |

| 2. Membership Status (select one) | |
|-----------------------------------|----------|
| New | Renewing |

3. I am requesting Membership Reimbursement (employee only)

Attach appropriate documentation (e.g. receipts, membership contract)

| Club Name/Fitness Expense | Date Range Being Claimed (Month/Year – Month/Year) | \$ Amount Being Claimed |
|---------------------------|---|-------------------------|
| | | |
| | | |

I understand that:

- The Healthy Lifestyle program provides for reimbursement up to a maximum of \$324.00 for an annual **employee only** health club membership (no family or add-ons) or fitness expense.
- The County paid membership is a taxable benefit and will be added to my taxable gross income.
- The County reserves the right to verify the information I provide.

I certify that:

- The amount being claimed is for **employee only** health club membership.
- All of the information above is full, complete, and true.

| | |
|--------------------|------|
| Employee Signature | Date |
|--------------------|------|

This document/form incorporates use of e-signature(s) in accordance with the San Bernardino County Policy #03-12 and Standard Practice 1.

| Office Use Only | | | | | |
|-------------------------|----------|--------|---------------------------------|-------|------------|
| Eligibility Verified by | | | | | Date |
| EMACS elig. | 12-month | Single | SBCERA | LAFCO | IVDA/SBIAA |
| Title | | | Date Last Application Submitted | | EXM Group |