THE LAKE COUNTY, INDIANA N.E.C.A. – I.B.E.W. HEALTH AND BENEFIT PLAN

FITNESS CLUB STIPEND REQUEST FORM

NAME: ____

STREET: ____ CITY: _________________

STATE: ______________ ZIP CODE: ___________ SOCIAL SECURITY #: XXX-XX-______

MEDICAL ID #: ______________________________ CELL PHONE #: ________________

E-MAIL ADDRESS: ____________________________________

I ___________________________________, understand that:
(Print Name)

1. The Plan will only consider a maximum of 1 workout per day.
2. That this benefit is only available to the employee and their listed spouse.
3. That I and/or my spouse must submit separate request forms in order to receive this benefit.
4. That the frequency of my workouts determines the level of reimbursement I will be entitled to receive.
5. That the Plan determines my monthly stipend by applying the following formula:

   The cost of my annual membership fee plus any monthly gym fee/by the number of months in which I had eight or more visits in that calendar month.

6. That the Plans stipend will not exceed the actual monthly cost of my membership, nor surpass the stipend levels identified directly below, whichever is less.

MAXIMUM MONTHLY HEALTH CLUB BENEFIT

NUMBER OF VISITS	POLICY HOLDER ONLY	POLICY HOLDER AND SPOUSE
8 to 11 visits per month	$12	$24
12 or more visits per month	$25	$50

I hereby attest that I understand the aforementioned provisions and wish to apply to receive the Lake County Indiana N.E.C.A. - I.B.E.W. Health and Benefit Plan's Fitness Club Stipend. I further confirm that, pursuant to IRS rules, payments for fitness memberships are considered taxable income in the year that I receive the benefit. For that reason and because the current level of the Plans benefit stipend is under the Internal Revenue Code threshold that requires the issuance of a 1099, I understand and agree that:

- It is my responsibility to declare as earned income on my annual tax filing any and all reimbursement you receive for this benefit. And,

- That the Health and Benefit Plan will not be issuing 1099 forms.

Signature: ____ Date: ___________________

DIRECT DEPOSIT

I wish to receive said monies via direct deposit to the account at the financial institution that I have listed within this document. As such, I hereby authorize the Lake County Indiana N.E.C.A. – I.B.E.W. Health and Benefit Plan to initiate credit entries to my account listed below, in the financial institution shown. In the event a credit is made to my account in error, I authorize the Lake County Indiana N.E.C.A. – I.B.E.W. Health and Benefit Plan to make a correcting entry, provided I am notified of the adjustment. This authorization is to remain in effect until the Lake County Indiana N.E.C.A. – I.B.E.W. Health and Benefit Plan has received written notification from me terminating it.

Participant Signature: ____ Date: ___________

Institution Name

Mailing Address

City **State** **Zip**

ABA Routing Number **Account Number** ○ **Checking** ○ **Savings**

DO NOT WRITE BELOW THIS AREA

Approved: YES NO

____ DATE ________________

Authorized Fund Signature

Lake County Indiana N.E.C.A. – I.B.E.W. Health and Benefit Plan - 7200 Mississippi Street, Suite 300, Merrillville, Indiana 46410. (219) 845-4433