

ASSOCIATED FOOD STORES FITNESS FUNDS CLAIM FORM

Employee Name:	Employee #:
Phone #:	Extension #:
Store Name:	Store #:

Tier 1: Healthy Behaviors (\$100 maximum)

Date of service	SCREENING	NOTES	FITNESS FUNDS AMOUNT	TOTAL
	Annual Physical (by Primary Care Physician)		\$ 40.00	
	Colon Cancer Screening (Fecal Occult Blood)		\$ 10.00	
	Colon Cancer Screening (Colonoscopy)		\$ 25.00	
	Dental Exam	2 exams / year \$10 per exam (\$20 annual max)	\$ 10.00	
	Depression Screening		\$ 10.00	
	Eye Exam		\$ 10.00	
	COVID Vaccine (requires full manufacturer-recommended doses) TEAM MEMBERS ONLY	Separate from \$100 max on tier	\$ 50.00	
	Flu Shot		\$ 5.00	
	Glaucoma Screening		\$ 10.00	
	Hearing Screening		\$ 10.00	
	Mammogram		\$ 25.00	
	PAP Test (Women Only)		\$ 10.00	
	Prostate Cancer Screening – PSA (Men Only)		\$ 10.00	
	Prenatal Visits		\$ 10.00	
	Skin Cancer Screening		\$ 10.00	
TOTAL				\$ -

Tier 2: Healthy Activities (\$100 maximum)

Date completed	SCREENING	NOTES	FITNESS FUNDS AMOUNT	TOTAL
	Exercise / Activity Log (12-weeks) (4/yr)	\$25 per log	\$ 25.00	
	Educational Class/Event	\$10 per class	\$ 10.00	
	Athletic League Participation	\$10 per league	\$ 10.00	
	Nutritional Consultation	\$25 per 2 consults	\$ 25.00	
	Exercise/Lifestyle Program	\$25 per program	\$ 25.00	
	Care Management Program	\$50 per program	\$ 50.00	
	Diabetes / Hypertension Coaching Program		\$ 100.00	
	Select Health Individual Healthy Habit Challenges		\$ 5.00	
	Participate in 2 or more 5k walk/runs or 10k races, or 1 Half-Marathon or longer		\$ 25.00	
	Participate in 2 or more bike races that are 49 miles or less or 1 bike race that is 50 miles or more (i.e., MS Bike Race, etc.)		\$ 25.00	
TOTAL				\$ -

I understand that I alone am fully responsible for the accuracy of all information I have provided by submission of this claim form and that all eligible items listed above for which I am seeking Healthy Lifestyle Rewards were completed by me or my AFS insured spouse. I further understand that falsification of any information could result in disciplinary action up to and including my termination.

Employee Signature:	Date:
----------------------------	--------------

Questions: Return this form and supporting documentation to:

801-978-8368 Mailing Address:
Team Services Wellness Facilitator
 PO Box 30430
 Salt Lake City, UT 84130

E-Mail:
NMBennion@afstores.com

FAX:
 801-978-8421

*****INCENTIVE ITEMS MUST BE TURNED IN WITHIN 6 MONTHS OF THE COMPLETION DATE*****