ASSOCIATED FOOD STORES FITNESS FUNDS CLAIM FORM

Employee Name:	**Employee #:**		
Phone #:	**Extension #:**		

Tier 1: Healthy Behaviors ($150 maximum)

Date of service	SCREENING	NOTES	FITNESS FUNDS AMOUNT	TOTAL
	Annual Physical (by Primary Care Physician)		$ 40.00	
	Colon Cancer Screening (Fecal Occult Blood)		$ 30.00	
	Colon Cancer Screening (Colonoscopy)		$ 50.00	
	Dental Exam	2 exams / year $10 per exam ($20 annual max)	$ 10.00	
	Depression Screening		$ 10.00	
	Eye Exam / Glaucoma Screening		$ 10.00	
	COVID Vaccine (requires full manufacturer-recommended doses) TEAM MEMBERS ONLY	**Separate from $150 max on tier**	**$ 100.00**	
	Covid Booster (Team Member Only)		$ 25.00	
	Flu Shot (Team Member Only)		$ 25.00	
	Flu Shot Spouse		$ 10.00	
	Hearing Screening		$ 10.00	
	Mammogram		$ 50.00	
	PAP Test (Women Only)		$ 20.00	
	Cervical Screening (Women Only)		$ 50.00	
	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/year)	**$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 or Two Activity Campaigns	**$25 per program**	$ 25.00	
	Chronic Conditions Program (Asthma, COPD, Diabetes, Heart Failure)	**$50 per program**	$ 50.00	
	Weigh to Health or any Diabetes Prevention Program		$ 100.00	
	One Digital Coaching Journey (4/year)		$ 10.00	
	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:

801-978-8368

Return this form and supporting documentation to:

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

E-Mail:
wellness@afstores.com

FAX:
801-978-8421

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

Revised 11/22/21