

EMPLOYER INFORMATION

Name: _____

Adress: _____



Diocese of Austin

Weight Watchers' Program

Reimbursement

Name as it appears on BCBS card: _____

Employee must provide proof of payment and attendance to the Weight Watchers Program.

Please attach a copy of your receipt .

Amount Paid: \$ _____

Amount Reimbursed: \$ _____

(Should equal to 50% of the amount paid)

Reimbursements processed quarterly:

Payment Schedule

Period	Date Due
Jul – Sept	10/09/2020
Oct – Dec	01/08/2021
Jan – Mar	04/09/2021
Apr – Jun	07/09/2021

*The wellness incentive is a taxable benefit. Because of this, your employer will need to include this in your normal pay.