WageWorks
www.wageworks.com

PHILLIPS 66
Fitness Reimbursement Program
Pay Me Back Claim Form

REIMBURSEMENT CLAIM FORM INSTRUCTIONS

PLEASE READ BEFORE SUBMITTING YOUR CLAIM FORM

The Phillips 66 Fitness Reimbursement Program reimburses you and your dependents for 100% of the annual cost of a fitness membership (up to $300 per person). Your eligible dependents include spouses and children age 13-26 that are enrolled in a Phillips 66 medical plan.

Employees

- Complete the Phillips 66 Fitness Reimbursement Claim Form with your information for your expenses.
- The ID Code will always be the last 4 digits of your Employee ID Number.
- Submit your Phillips 66 Claim Form with a receipt. You will be reimbursed up the maximum reimbursement amount or your annual membership dues for the year, whichever is less. If you submit receipts for anything other than your single membership, such as a dual or family membership, please provide a per person amount. Dependent expenses must be filed separately with their own claim form as noted below.
- Fax toll-free to fax number: 877-353-9236 the completed claim form, along with the appropriate documentation of payment.
- Please note: If you and your spouse are both Phillips 66 employees, then you will each file as an employee.

Dependents:

- Complete one Phillips 66 Fitness Reimbursement Claim Form for each dependent's fitness expenses.
- The ID Code will always be the last 4 digits of the dependent's Social Security number.
- Submit your Phillips 66 Claim Form with a receipt, or statement showing payment in full for the membership. You will be reimbursed up the maximum reimbursement amount or your annual membership dues for the year, whichever is less.
- Fax toll-free to fax number: 877-353-9236 the completed claim form, along with the appropriate documentation of payment.

Reimbursements:

- Payment for approved claims will appear on the first available paycheck of the month. Payment will also include reimbursements for eligible dependents, if applicable.
- Once you've submitted your claims to WageWorks, you will receive reimbursement for eligible expenses on your paycheck as soon as administratively possible.
- Your claims for reimbursement should be received no later than 90 days following the end of the plan year.

Expenses incurred overseas:

- For expenses incurred in non-US locations, please ensure that claim form is completed in English; receipts submitted in other languages will be accepted, however, they should be translated into English. All expenses should be submitted in U.S. Dollars on the receipt and on the claim form.

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CLAIM FILING OPTIONS:

- **Toll-free Fax:** 877-353-9236.
- **Mail:** CLAIMS ADMINISTRATOR, P.O. Box 14053, Lexington, KY, 40512

ACCOUNT HOLDER INFORMATION

Last Name

First Name

ID Code (Last 4 digits*)

Employer / Program Sponsor's Name: PHILLIPS 66

Zip Code

Birth Month/Day (MM/DD/YY)

Email address (optional)

CERTIFICATION AND AUTHORIZATION

I certify by submitting this claim that:

1. The information on this page is accurate and complete.
2. I am requesting reimbursement for my own personal expenses.
3. These services have already been purchased.
4. I have not and will not seek reimbursement of this expense from any other plan or party.
5. Use of this service indicates my acceptance of the WageWorks User Agreement at **www.wageworks.com** (available upon registration; enter username and password or clink on Employee Registration).
6. I understand that reimbursement will be processed as soon as administratively possible.

RECEIPT REQUIREMENTS

The following information must appear on the receipt: (1) Employee or dependent name (printed or handwritten on receipt), (2) Name of service provider (printed on receipt), (3) Description of service (printed or handwritten on receipt), (4) Amount (printed on receipt), (5) Service Dates (printed or handwritten on receipt).

The cost for each employee and/or dependent will need to be submitted under the employee and/or dependents individual account.

CLAIMS FOR OUT-OF-POCKET FITNESS EXPENSES

YOU MUST ATTACH APPROPRIATE PROOF OF PURCHASE OR EXPENSE

NAME OF SERVICE PROVIDER	TYPE OF SERVICE	DATES OF SERVICE	OUT-OF-POCKET COST
1	☐ Membership/Fees ☐ Gym Dues ☐ Other:_____		$
2	☐ Membership/Fees ☐ Gym Dues ☐ Other:_____		$
3	☐ Membership/Fees ☐ Gym Dues ☐ Other:_____		$
		TOTAL THIS FORM	$

* The ID Code for employees is the last 4 digits of the Employee ID code and the ID Code for dependents is the last 4 digits of the dependent's Social Security number.

- **Send a photocopy of your receipt.**
- **Send photocopy of documented visits.**
- **Keep original receipt with a copy of this completed form.**