TRANSPORTATION COMMUNICATIONS INTERNATIONAL UNION
LOS ANGELES METROPOLITAN TRANSPORTATION AUTHORITY

TCU LOCAL 1315 Wellness Extra Mile Program

Employee Section

1. Full Name:		2. Soc. Sec No.	
3. Patient's Full Name		4. Relationship	
5. Provider's Name		6. Type of Service:	

Type or print information (items 1 through 6) on the Employee Section above. ONLY ONE PROVIDER CAN BE LISTED ON A REQUEST FORM.

Enter total amount for which claim is being made in the appropriate sections. Accumulate at least $50 in expenses to be reimbursed before submitting a claim.

To receive reimbursement, you must provide the following:

Alternative Remedies
☐ Coverage includes Non-FDA approved medications, homeopathic, vitamins and mineral supplements. Books and consultation fees will not be covered.

Smoking Cessation Programs
☐ Participation in a smoking cessation program while under a physician's care will be covered. In addition, the cost of over-the-counter smoking cessation medications/aids will be reimbursed provided an itemized receipt and proof-of-purchase seal has been submitted with your claim.

Physical Therapy and Chiropractic
☐ Physical Therapy and Chiropractic benefits not covered through your medical plan are eligible for reimbursement.

Items you will need a letter from a Medical Professional:

- ☐ Vitamins
- ☐ Supplements
- ☐ Powders
- ☐ Workout Equipment (examples: Treadmill, Rowing Machine, Weights)

Items now covered needing a receipt for reimbursement:

- ☐ Yoga
- ☐ Pilates
- ☐ Massages
- ☐ Acupuncture
- ☐ Acupressure
- ☐ Chiropractor
- ☐ Gym Membership
- ☐ Martial Arts/CrossFit/Boxing
- ☐ Personal Training
- ☐ Float Therapy
- ☐ Weight Management Programs
- ☐ Sauna Services
- ☐ Red Light Therapy
- ☐ Healthy Food Plans/Meal Plans
- ☐ Food Plan Counseling
- ☐ Body Fat Percentage Testing
- ☐ IV Therapy
- ☐ Holistic Detox Therapy

Retain copies of supporting documentation for your records as those submitted will not be returned.

Send a completed claim form(s) and the supporting documentation directly to the following address:

TCU-MTA Trust Fund
1200 Wilshire Blvd., Fifth Floor
Los Angeles, CA 90017
(562) 463-5090 (800) 427-5342

WELLNESS PLAN EXPENSES: _____ $ _____

DATE OF SERVICE *CLAIM AMOUNT TO BE REIMBURSED*

Declaration:

I certify that either myself and/or my eligible dependent(s) have incurred the expenses for which reimbursement is claimed under the Wellness Plan.

_____ _____

EMPLOYEE SIGNATURE *DATE*