ANALOG DEVICES

AHEAD OF WHAT'S POSSIBLE™

Analog Devices, Policy Number 908715

Weight Loss Program Membership Reimbursement Request

Identification Number (ID #): _____

Employee Name: _____

Address: _____

_____

Member Name: _____

Relationship (check one): Subscriber _____
Dependent _____

Weight loss membership **code S9449** $_____

All benefit payments will be sent to the subscriber's address on file.

Certification and Authorization (this form must be signed and dated below)

I authorize the release of information to UnitedHealthcare about my weight loss program membership. I certify the information provided is complete and correct and that I have not previously submitted for reimbursement of these expenses.

Subscriber/Member
Signature_____Date_____

Submit this completed form with receipts to: **UnitedHealthcare**
PO Box 740827
Atlanta, GA 30374