

EMPLOYER INFORMATION

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_



**Diocese of Austin**

**Weight Watchers' Program**

**Reimbursement**

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

\_\_\_\_\_

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

Please attach a copy of your receipt and attendance card.

Amount Paid: \$ \_\_\_\_\_

Amount Reimbursed: \$ \_\_\_\_\_

(Should equal to 50% of the amount paid)

Reimbursements processed quarterly:

**Payment Schedule**

Period	Date Due
Jul – Sept	10/13/2017
Oct – Dec	1/12/2018
Jan – Mar	4/13/2018
Apr – Jun	7/13/2018

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