

Weight Watchers Proof of Participation Form

PEBB Employee to Complete - **PLEASE NOTE NEW RENEWAL FAX NUMBER**



To qualify for another Weight Watchers series, you must first fax this form to 1-888-598-7704 showing proof of participation in at least 10 weeks of your prior Weight Watchers series. **No exceptions will be made.** Follow the instructions below to rejoin! **Form must be filled out in its entirety to qualify.**

1. Check the applicable Weight Watchers service you've just completed

I participated in at least 10 weeks of the following plan: At Work Meeting Traditional Meeting Online Subscription

I participated in at least 8 weeks of a series in Southern Oregon: Traditional Meeting

Participation Dates: Start Date _____ End Date _____

2. Proof of Participation.

At Work or Community Meetings: Ask your Weight Watchers leader or receptionist to certify and sign below:

I certify that _____ has attended a minimum of _____ weekly meetings.

Weight Watchers Leader/Receptionist Signature and Leader ID# Meeting Name/Location # Date

Online Subscription: attach copy of *Weight Tracker summary* showing minimum 10 weeks participation of your 3-month subscription.

3. Read Terms and Conditions Confirm Method of Return Communication and Sign.

By providing the above information and submitting this form, I acknowledge and agree to the following Terms and Conditions: Offer is valid for Weight Watchers programs beginning on or after January 2010. Eligibility is limited to active PEBB employees. Keep copies of all material submitted. Weight Watchers and PEBB are not responsible for lost, late or misdirected forms. Upon receipt and validation of your request, you will be reissued a new Weight Watchers Access Code which will allow you to rejoin Weight Watchers. The information submitted on this form will be used solely to process your request. All information is required! Please print clearly

Last Name _____ First Name _____ MI _____

Health Plan ID Number _____

Health Plan (circle your plan) PEBB Statewide Plan Providence Choice Kaiser Permanente

Address _____ City _____ State _____ Zip _____

Email Address _____ Phone Number _____

(Please write clearly!)

Signature _____ Date _____

4. Preferred method of return communication (must be completed to receive new renewal access code)

Call me at: _____ or Email me at this address: _____

If you have specific questions about your health plan please contact them directly at the number listed on your insurance card.