Smoking Cessation Reimbursement Request

Associate Name _____ Division/Loc: _____

Address _____ Date of Birth: _____

Address _____ Employee ID: _____

City, State Zip _____

See page 2 for information on the reimbursement program and how to submit this form.

Claim 1

CLAIMS FOR OUT-OF-POCKET EXPENSES (INCOMPLETE ITEMS MAY RESULT IN YOUR CLAIMS BEING DENIED)

- ☐ Classes/Programs
- ☐ Nicotine Gum
- ☐ Nicotine Patch (over-the-counter)
- ☐ Nicotine Lozenges
- ☐ Other_____

Claimant Relationship to Associate

- ☐ Self (Associate)
- ☐ Spouse
- ☐ Dependent

Claimant's Name: _____ Service Date: _____

Claim 2

CLAIMS FOR OUT-OF-POCKET EXPENSES (INCOMPLETE ITEMS MAY RESULT IN YOUR CLAIMS BEING DENIED)

- ☐ Classes/Programs
- ☐ Nicotine Gum
- ☐ Nicotine Patch (over-the-counter)
- ☐ Nicotine Lozenges
- ☐ Other_____

Claimant Relationship to Associate

- ☐ Self (Associate)
- ☐ Spouse
- ☐ Dependent

Claimant's Name: _____ Service Date: _____

Claim 3

CLAIMS FOR OUT-OF-POCKET EXPENSES (INCOMPLETE ITEMS MAY RESULT IN YOUR CLAIMS BEING DENIED)

- ☐ Classes/Programs
- ☐ Nicotine Gum
- ☐ Nicotine Patch (over-the-counter)
- ☐ Nicotine Lozenges
- ☐ Other_____

Claimant Relationship to Associate

- ☐ Self (Associate)
- ☐ Spouse
- ☐ Dependent

Claimant's Name: _____ Service Date: _____

Claim 4

CLAIMS FOR OUT-OF-POCKET EXPENSES (INCOMPLETE ITEMS MAY RESULT IN YOUR CLAIMS BEING DENIED)

- ☐ Classes/Programs
- ☐ Nicotine Gum
- ☐ Nicotine Patch (over-the-counter)
- ☐ Nicotine Lozenges
- ☐ Other_____

Claimant Relationship to Associate

- ☐ Self (Associate)
- ☐ Spouse
- ☐ Dependent

Claimant's Name: _____ Service Date: _____

CERTIFICATION AND AUTHORIZATION

I certify that the information on this form is accurate and complete. I am requesting reimbursement for eligible smoking cessation expenses incurred by myself or an eligible spouse/dependent. I have already received these products or services and have not and will not seek reimbursement of this expense from any other plan or party other than normal copays through my insurance plan.

_____ _____

Signature of Associate Date

WHAT IS THE SMOKING CESSATION REIMBURSEMENT PROGRAM?

The Marcus Corporation will reimburse covered members (includes benefit-eligible associates, spouses and/or dependents) for the costs of prescription copays, prescriptions not covered by your health plan, over-the-counter products and classes/programs specifically marketed for the purpose of smoking cessation at the rate of 50% of the cost, up to a total of $250 reimbursed per covered member per year.

Other stop-smoking aids such as prescription drugs, education, and support, may be available to you through your health plan or the Aurora Employee Assistance Program (EAP). See your plan information or Human Resources for details.

HOW DO I GET REIMBURSED?

Complete the form on page 1. The form is designed so that multiple claims can be submitted using the same sheet. Use additional sheets for more than 4 claims. For "Claimant's Name" please list the person for whom the items or classes/programs were purchased. Be sure to sign and date the form at the bottom of the page. Then, send this form along with itemized receipts for smoking cessation items and classes to:

The Marcus Corporation
Attn: Corporate Benefits
100 East Wisconsin Avenue, Suite 1900
Milwaukee, WI 53202

Or fax to: (414) 905-2129

If you should have any questions regarding what to submit, you may contact Corporate Benefits at (414) 905-1000.

You can expect to receive your reimbursement in the mail within 4 weeks of submission of this claim form.