



Wellness Expense Benefit Form: MPC

If you are unsure whether a specific activity qualifies for reimbursement, please call the **Health Services' Wellness Helpline 1-866-808-5706**. Please note that you cannot also receive reimbursement for these expenses from your Health Savings Account, Flexible Spending Account or any other health plan or reimbursement arrangement, including a spouse's health plan. Also, the expenses reimbursed through the Wellness Program cannot be used as a deduction on your personal income tax return.

All US Payroll MPC regular active employees and regular employees on temporary leave, and their eligible dependents can participate in this benefit. Please note that the yearly **WELLNESS ASSESSMENT MUST BE COMPLETED** to receive reimbursement. The Wellness Expense Benefit for qualified fitness activities and services is a maximum of \$350 per family and \$200 single. In addition, this benefit covers Weight Watchers™ membership fees up to \$200/participant/year. Please visit www.myMPCWellAllWays.com for more information.

Mail the form and proof of purchase to:
**Health Services, Room 999-M
 Marathon Petroleum Company LP
 539 S. Main St.
 Findlay, OH 45840**
OR
 Send electronically to Outlook mailbox:
Wellnessbenefit@marathonpetroleum.com

The completed reimbursement form signed by the employee and proof of purchase(s) for qualified activities purchased between January 1 and December 31, MUST be postmarked by U.S. Postal Service no later than January 31 of the next calendar year to be eligible for reimbursement. If sent in intra-company mail, Findlay Health Services must receive the form no later than January 31. If sent electronically, keep a copy of your outgoing documentation for your records until your claim has been reimbursed in your pay check. **You will receive reimbursement through your company's payroll in approximately 6-8 weeks. Legally required taxes will be withheld.**

1. Employee Name:		2. Employee Number:		3. Date:	
4. Home Address:		5. City:		6. State:	7. Zip Code:
8. Daytime Phone:			Is this a Family Reimbursement? <input type="checkbox"/> Yes <input type="checkbox"/> No		
9. Date of Purchase (month/date/yr)	10. Description of Activity or Membership		11. Amount Paid	12. Who attended? (circle one) E = Employee F = Family Member (Write Name) B = Both	
			\$	E	F B
			\$	E	F B
			\$	E	F B
			\$	E	F B

I acknowledge that participation in the Well ALL Ways Wellness Expense Benefit program is voluntary, and that participation is at the risk of the participant. I further understand that my employer (Marathon Petroleum Company LP or their respective subsidiaries), their subsidiaries, affiliates and their officers, agents, and employees are not liable for any injury, illness or death which may result from my or my family's participation in any activity, service or use of equipment reimbursable under this program. I understand that my employer does not endorse or guarantee the safety or quality of the activities, services or equipment that the program reimburses. I certify that the information on this claim form and on the proof of purchases submitted is accurate. I authorize the release of any reimbursement information to my employer to determine the validity of this claim.

Employee Signature: _____ **Date:** _____