



TechFit Wellness Program Benefit Form

MTU ID #:

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Employee Name: _____

TechFit Eligibility:

Employee: _____ Cost: _____

Dependent: _____ Cost: _____

Facility/Class/Instructor : _____

Earnings Code:

T	F	T
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Hours/Units:

		1.	0	0
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Bi-weekly Amount:

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(To be taxed each pay period)

Goal Amount:

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(Total TechFit benefit approved)

I understand that the amount paid on my behalf for the TechFit Wellness Program will be subject to social security, federal and state withholding on the next paycheck(s) from date of signature.

Employee Signature: _____

Date _____

Benefits Office

Approval: _____

Date _____