



## Good Health Bonus Redemption Form

Please complete this form and return to:  
Physicians Plus Insurance Corporation  
Attn: Good Health Bonus  
P.O. Box 2078  
Madison, WI 53701-2078

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Member Number \_\_\_\_\_

Class Attended \_\_\_\_\_ Location \_\_\_\_\_

Class Completion Date \_\_\_\_\_

Bonus Amount \_\_\_\_\_

Instructor's Signature \_\_\_\_\_