

**NECA-LOCAL NO. 145 IBEW WELFARE FUND
HEALTH REIMBURSEMENT ACCOUNT PROGRAM
MEDICAL REIMBURSEMENT REQUEST FORM**

Member Information

Name _____ Social Security Number _____

Address _____

Instructions: Complete the table on the reverse side of this form for eligible expenses incurred by you and/or your Dependents. **The minimum amount for medical reimbursement is \$100.00.** Requests must be received by the Fund Office no later than one year (12 months) following the date which the expense was incurred. Please sign and date this Form, then send it, along with your supporting documentation, to the Fund Office 1700 52nd Avenue, Ste. B, Moline, Illinois 61265 Attn: Claims Coordinator. Requests received by the Fund Office on or before the last business day of the month will be processed early the next month. If the member is entitled to reimbursement under the rules & provisions of this Plan, the reimbursement check will be issued on or about the fifteenth day of the month following the month in which the request was received. Requests that are submitted to the Fund Office on a non-business day **WILL BE** dated as being accepted on the next business day.

INFORMATION THAT MUST BE PROVIDED BEFORE MEDICAL REIMBURSEMENT WILL BE ISSUED

1. Completed Reimbursement Request Form,
2. Itemized bill from the provider, receipt showing proof of payment or other evidence that qualified medical expenses were incurred,
3. Check the boxes below that apply,
 - All explanation of benefits (EOBs) from any insurance companies involved in paying medical expenses are enclosed.
 - If the patient listed is a Dependent he and/or she was or will be claimed as a Dependant on my most current Federal Income Tax Return for the period during which the expense was incurred.
4. **Any part of this form that is not completed properly and/or any documentation of Qualified Medical Expenses which are not submitted, will be returned to the member without reimbursement,**
5. **PLEASE USE THE REVERSE SIDE OF THIS FORM FOR MEDICAL REIMBURSEMENT REQUESTS.**

To the best of my knowledge & belief, my statements on this Form are complete & true. I certify all of the following: Either I have or a Dependent has received the services described on the reverse side of this form on the dates indicated and the expenses are my out-of-pocket expenses that qualify as valid qualified medical expenses under the Plan. **If the expense is for a Dependent, the person listed as a Dependent was or will be claimed as a Dependent on my Federal Income Tax Return for the period during which the expense was incurred.** I have not been reimbursed previously for these expenses under the Health Reimbursement Account Program. These expenses have not been reimbursed or are not reimbursable under any other source available for reimbursement (e.g. the Fund's health plan or any other health plan, such as my Spouse's plan). I understand that the expenses reimbursed may not be used to claim any federal income tax deduction or credit. I authorize a deduction in my Health Reimbursement Account in the amount of the reimbursement.

EMPLOYEE'S SIGNATURE _____

DATE _____

