Welfare Reimbursement Account (WRA)
Claim Form

(TO BE COMPLETED BY THE PARTICIPANT)

IBEW LOCAL NO. 150 FRINGE BENEFIT FUNDS

PLEASE PRINT ALL INFORMATION

Participant Name: (Please Print)	
Member ID or SSN:	
Local Union Number:	
Participant Date of Birth:	

Address:	**City, State, ZIP:**

Reimbursement Request:

For each medical, dental, or vision reimbursement request, you must submit the following:

- **Explanation of benefits (EOB) for each medical/dental/vision expense submitted**
- **For prescription drug reimbursement requests, you must submit an itemized receipt or printout from the pharmacy**
- **If there is not enough in your account to cover the full amount requested, a check will be issued for the balance of your WRA account.**

SELF-PAYMENTS – In order to use your WRA account for your self-payments*, this form must be completed and in the Fund Office by the date specified on your self-payment notice.

Total amount submitted from EOB's:	$
Total amount submitted from Prescription receipts:	$
Total amount submitted from self-payments*	$
Total anticipated reimbursement:	$

I hereby certify that the expense for which I am requesting reimbursement have been paid in full.

Signature: _____ Date: _____

Participant Telephone Number: _____

(*self-payments refer to the payments that you make to continue your coverage with the Fund)

RETURN THIS COMPLETED FORM TO:

IBEW LOCAL NO. 150 FRINGE BENEFIT FUNDS
230 LEXINGTON GREEN CIRCLE STE 400
LEXINGTON KY, 40503
or email to ibew150fundadministrator@umr.com