Welfare Reimbursement Account Claim Form

Part A:
PERSONAL INFORMATION

Last Name | First Name | Phone Number

Member ID Number | Name of Employer

Name of Employer: International Brotherhood of Electrical Workers Local No. 150 Welfare Fund

Part B:
REIMBURSEMENT INFORMATION

Service Date from | Service Date to | Reimbursement Requested $.

Provider Name | Type of Service*

Service Date from | Service Date to | Reimbursement Requested $.

Provider Name | Type of Service*

Service Date from | Service Date to | Reimbursement Requested $.

Provider Name | Type of Service*

Total Reimbursement .

Part C:
Attach **COPY** of itemized receipts.

* Be specific with the type of service

I certify that the expenses for which I am requesting reimbursement meet all the conditions listed below:

- They were incurred for services or supplies received by my eligible dependents or me under the plan.
- They were for services or supplies furnished on or after the effective date of my employee reimbursement account.
- I have not been reimbursed for these expenses in any other way or from any other source.
- They are for eligible expenses based on IRS section 213d and allowed per my employer's plan. Please refer to your Plan document to verify what expenses are allowed.

I understand that reimbursement of these expenses should be requested and made only after I have collected all benefit payments available from all plans under which my eligible dependents and I are covered.

****** Please note claims will be used to offset any improper/unsubstantiated debit card transactions before any reimbursement can be made. ******

I further certify that I have not deducted, nor will I deduct on my individual tax return any of the expenses reimbursed through my healthcare reimbursement account. I understand that reimbursement will be made in accordance with the provisions of the plan. I accept sole responsibility for the proper treatment of benefits paid under this plan with respect to eligibility, income tax reporting and liability. UMR shall not be liable for any penalties or damages because of an inappropriate claim filed by me. I will retain a copy of this form and all original receipts for my records.

Employee Signature | **Date**

FAX: 877-390-4782
MAIL: UMR / PO Box 8022 / Wausau, WI 54402-8022
EMAIL: umr-fsa@umr.com
INQUIRIES: 800-826-9781 and say ***consumer accounts*** when prompted

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Reimbursement Instructions

Eligible Services and Documentation Requirements:

The expense must be a health-related expense incurred by you or one of your tax dependents. This means amounts paid for the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure of the body. Expenses must be medically indicated and not for cosmetic purposes or general good health.

Supporting Documentation must accompany this request form. Please adhere to the following guidelines:

DO	DO NOT
➢ Send an itemized bill showing the dates of service, type of service, provider name, patient's name and amount of service ➢ Send a copy of an explanation of benefits (EOB) from any insurance plan under which the expense is covered, when applicable your insurance claim must be finalized prior to submitting for flex reimbursement ➢ Complete the total requested amount ➢ Send the documentation on white paper, carbon copies and colored paper are not legible when scanned ➢ Tape small receipts to a standard 8.5" x 11" sheet of blank paper and ensure print is legible ➢ Include itemized receipts and documentation with the form ➢ Make a copy of the form and documentation for your personal records	➢ Do not submit cancelled checks or credit card receipts alone, these are not adequate documentation without supporting itemization ➢ Do not submit balance forward statements ➢ Do not submit bank statements ➢ Do not highlight names, prices or dates on receipts, doing so makes them illegible when scanned ➢ Do not submit handwritten receipts for prescriptions ➢ Do not submit pre-treatment estimates or estimated insurance statements ➢ Do not submit date expense was paid, except for orthodontia payments

Actual Dates of Service must be indicated on the claim form. The IRS allows reimbursement for services when the care is provided, which may not be the actual date that the patient pays or is formally billed for the charges.

EOB E-mail Notification allows you to receive an e-mail notifying you once your claim has been processed and an EOB is available to view online. Signing up is easy and convenient at www.umr.com.

Web Claim Submission allows you to submit your claim online at www.umr.com, and upload your supporting documentation.

Letter of Medical Necessity (LOMN) is additional documentation needed when an item normally not considered eligible is needed to treat a specific medical condition. This letter would need to be completed by your provider stating which service or item is needed and for what type of condition. A LOMN is required annually. If you are not sure if a service or item will be covered, please review the listing of eligible/ineligible items available online, refer to your plan document or please contact UMR customer service.

Examples of items needing a LOMN are 1) massage therapy 2) weight loss programs.

Payments are issued once the total reimbursement amount reaches your plan's check minimum. Please contact UMR customer service to verify this amount.