A UnitedHealthcare Company

IBEW Welfare Reimbursement (WRA) Claim Form

Part A: Personal information

Last name _____ First name _____ Phone number ___ - ___ - ____

Member ID number _____ Name of employer **International Brotherhood of Electrical Workers No. 150**

Email address _____

Part B: Claim reimbursement information

Total amount submitted from EOB's $ _____

Total amount submitted from prescription receipts $ _____

Total reimbursement **$** _____

Part C: 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 notices. Effective 1/1/26, recurring auto-pay claims are allowed to span over multiple plan years. However, if your premium amount changes, a new self-pay recurring auto-pay claim form **must** be submitted to UMR.

Start date of payment ___/___/____ (MM DD YYYY) End date of payment ___/___/____ (MM DD YYYY) Amount of self-payment $ _____

What type of self-pay claim are you submitting? Please select from the following:

☐ Self-pay reimbursement ☐ Self-pay reimbursement auto-pay (recurring claim)

☐ Self-pay balance reduction (quarterly self-pay premiums due to hours worked/eligibility)

Total reimbursement from Part B + Part C $ _____

Part D: Certification

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

- Expenses were incurred for services or supplies received by my eligible dependents or me under the plan.
- Expenses 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.
- Expenses are eligible based on IRS section 213d and allowed per my employer's plan. Please refer to 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.

Employee signature _____ Date ___/___/____ (MM DD YYYY)

Email: **umr-fsa@umr.com**
Mail: **UMR / P.O. Box 8022 / Wausau, WI 54402-8022**
Fax: **877-390-4782**

(Continued)

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

- Send an itemized bill showing the dates of service, type of service, provider name, patient's name and cost 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 in each section
- 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 either an itemized receipt from your provider **or** the explanation of benefits from your insurance with this claim form as substantiation
- Make a copy of the form and documentation for your personal records
- **If you are submitting a claim for Self-Payment reimbursement, please include documentation to substantiate the payment.**

Do not

- 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

Services must be submitted to UMR within 2 years from the date of service. The IRS allows reimbursement for services when the care is provided, which may not be the actual date that the expense is paid or is formally billed for the charges.

EOB email notification allows you to receive an email notifying you once your claim has been processed and an EOB is available to view online. Signing up is easy and convenient at **umr.com**.

Web claim submission allows you to submit your claim online at **umr.com** and upload your supporting documentation.

Letter of Medical Necessity (LOMN) is an additional document 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. An example item requiring a LOMN is weight loss programs.

Payments are issued once the total reimbursement amount reaches your plan's check minimum of $10.00. If there is not an available WRA balance at the time your claim is processed, your claim will be denied. You may resubmit your claim once additional contributions have posted to your plan.

UMR℠
A UnitedHealthcare Company