Inland Empire Electrical Workers
Supplemental Benefits Account Claim Form

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Post Office Box 5433 Spokane, WA 99205

PARTICIPANT INFORMATION

- PLEASE FILL OUT ONE CLAIM FORM FOR EACH INDIVIDUAL -

Name: _____ Account ID Number or SSN: _____ Date of Birth: _____

Mailing Address: _____ ☐ Check here if new address

City: _____ State: _____ Zip: _____ Phone: ( ) -

Patient Name (person incurring expense): _____

Relationship: ☐ Self ☐ Spouse ☐ Dependent ☐ Other: _____

SECTION A: REIMBURSEMENT REQUEST

Date(s) of Service	Provider Name	Expense Description	Amount
			$
			$
			$
			$
			$
			$
			$
			$

SECTION B: INSURANCE PREMIUM REIMBURSEMENT REQUEST

Name of Insurance Company	Monthly Premium Amount	Number of months paid	Total
	$		$
	$		$

NOTE: Premiums paid by an employer or through a pre-tax Section 125 Plan are not eligible for reimbursement.

TOTAL AMOUNT OF REIMBURSEMENT

Total amount of reimbursement for **Section A:** $

Total amount of reimbursement for **Section B:** $

Total Amount to be reimbursed: $

SIGNATURE

READ CAREFULLY: I hereby certify that (1) the information provided in this claim request is true and correct; (2) the amount of the submitted claim to the Third-party Administrator is an accurate statement of my unreimbursed medical/dental/vision expenses and/or medical/dental/vision/tax-qualified long-term care insurance premiums; and (3) the submitted claim is not reimbursable from any other source. Will respect to claims submitted on behalf of qualified dependents, I hereby certify that such person meets the Plan requirements as summarized on the reverse and is a qualified dependent as defined under the terms of the Plan. With respect to claims for qualified insurance premiums, I hereby certify that such premiums have not been paid by my employer and are not eligible for pre-tax deduction through my or my spouse's section 125 cafeteria plan.

Signature of Plan Participant _____ Date _____

~ INSTRUCTIONS FOR FILLING OUT CLAIM FORM ARE ON REVERSE SIDE ~

ALL CLAIMS MUST BE SUBMITTED TO INSURANCE PRIOR TO BEING REIMBURSED FROM THE SBA

INSTRUCTIONS FOR SUBMITTING CLAIM FORM:

Use this form to request reimbursement of qualified healthcare expenses and/or insurance premiums you have incurred on behalf of yourself, your spouse, and/or your eligible dependents. Qualified expenses and premiums submitted for reimbursement must have been incurred after you became a participant eligible to file claims and after insurance has processed your eligible expenses.

HOW TO EXPEDITE YOUR CLAIM

1. Email your claim to ieew@rehnonline.com; it is faster and more secure.
2. Fully complete all requested information. Missing information may delay the processing of your claim and could result in your claim being denied. Do not forget to sign and date the form.
3. You must attach detailed itemized verification for each expense or service. Verification should contain (1) patient (covered individual) name; (2) date the item was purchased or service was provided; (3) description of expense or service; and (4) out-of-pocket amount. Acceptable forms of verification include (1) an explanation of benefits (EOB) from the insurance; (2) a detailed itemized billing or statement from your provider; or (3) a detailed receipt for prescription or over-the-counter (OTC) medications. Cancelled checks and balance forward statements are **NOT** acceptable.

   NOTE: Please do not use a highlighter on your expense receipts. If you want to identify certain items on your receipts, circle the items with a regular pen instead. Highlighting often appears illegible on faxes and electronic imaging equipment to process your claim.
4. For qualified insurance premium reimbursement, you must attach documentation which includes the following; (1) name(s) of covered individual(s); (2) premium amount(s); (3) policy period; and (4) insurance provider name and address. This information is typically contained on your premium billing notice. NOTE: Premiums paid by an employer, or premiums that are or could be deducted pre-tax through your or your spouse's employer, are not eligible for reimbursement. If you request reimbursement of after-tax premiums deducted from your (or your spouse's) paycheck, you should include a letter from the employer which confirms that a pre-tax option for the payment of such premiums is not available.

QUALIFIED EXPENSES AND PREMIUMS

Internal Revenue Code 213(d) defines qualified expenses and premiums, in part, as "medical care" amounts paid by insurance "for the diagnosis, cure, mitigation, treatment, or prevention of disease…" Expenses solely for cosmetic reasons generally are not eligible (e.g. facelifts, hair transplant, hair removal, etc.).

Common expenses include co-pays, coinsurance, deductibles, and prescriptions. Common insurance premiums include medical, dental, vision, tax qualified long-term care (subject to IRS limits), Medicare Part B, Medicare Part D, and Medicare supplement plans. COBRA payments and Self-pay payments are reimbursable as well. Please note the following:

1. Insurance premiums paid by an employer or premiums that are, or could be deducted pre-tax through you or your spouse's section 125 cafeteria plan, are not eligible for reimbursement.
2. If you or your spouse has a section 125 healthcare flexible spending account (FSA), you must exhaust the FSA benefits before submitting claims.
3. Claims for over-the-counter (OTC) medicines and drugs should be for reasonable quantities expected to be consumed within a reasonable period of time. Sales tax can be included. As of January 1, 2011 all OTC items deemed as a DRUG or MEDICINE will now require a prescription or letter of medical justification from your doctor.

QUALIFIED DEPENDENTS

Eligible dependents are persons you could claim as a dependent on your personal income tax return as defined by the Internal Revenue Code Section 152. Qualified dependents are outlined in IRS Publication 501.