CLAIM FOR REIMBURSEMENT
IBEW/NECA SOUND & COMMUNICATIONS TRUST FUND
HEALTH REIMBURSENT CLAIM FORM

Name _____ Social Security #_____

Street Address _____ Phone #_____

City, State, Zip Code_____

Complete only the sections that apply to the claim you are submitting for reimbursement. Part 1 is for Unreimbursed Medical Expenses, Part 2 is for Authorization to Deduct Self Payment Amounts from your HRA Account to continue coverage. Payment for Medical Reimbursement will be issued to you once a month, provided you have a balance in your HRA Account. ***Please note that the HRA Funds are part of the Trust and that an HRA Account balance is not a vested benefit.***

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Part 1: UNREIMBURSED MEDICAL EXPENSES - Send Bills, Explanation of Benefits or other documents.

Date Incurred	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount
PLEASE READ CAREFULLY:			TOTAL AMOUNT CLAIMED:	

The undersigned participant in the plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form are for covered medical expenses. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including Federal, State or City Income Tax on amounts paid from the Plan which relate to such expense. It is the member's responsibility to keep copies of all claim forms and receipts for potential IRS Audits.

The undersigned certifies that the above Medical expenses have not been reimbursed and are not reimbursable under any other health plan coverage.

_____ _____

Employee's Signature **Date**

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PART 2: AUTHORIZATION TO DEDUCT SELF PAY PREMIUM FROM EXTENDED RESERVE ACCOUNT

My signature below is authorization to have the monthly premium amount required for Active Member self payment, Retiree Premium or COBRA coverage to be deducted from my HRA Account. I understand that payment deduction from my HRA Account will continue only under the terms of the IBEW/NECA Sound & Communications Health and Welfare Trust Fund rules of Self Payment and COBRA coverage. The authorization is for continuation of coverage as checked below. I may continue Medical Only Coverage or Medical and Dental Coverage. I may not continue Dental Only coverage.

Please check only one option:

I elect deduction of the required Medical Only Coverage: _____

I elect deduction of the required premium for Medical and Dental Coverage: _____

This authorization will remain in effect until the earliest of the following; a) such time as I am no longer eligible to continue coverage under the self pay rules or COBRA coverage, b) my HRA Account balance is exhausted or c) I rescind the authorization in writing. I understand if I rescind this authorization prior to the end of the period allowed by self pay rules, I can not later elect to use the HRA Account for any remainder of that entire period.

_____ _____

Employee's Signature **Date**