DATE OF SERVICE	PRINT PATIENT'S NAME	PATIENT'S RELATIONSHIP TO PARTICIPANT (Example Spouse, Son, Daughter)	PRINT PROVIDER'S NAME	TYPE OF SERVICE (Medical, Dental, Rx or Vision)	AMOUNT	FOR OFFICE USE ONLY
TOTAL						

LOCAL NO. 704 IBEW WELFARE FUND
HEALTH REIMBURSEMENT ARRANGEMENT PROGRAM
MEDICAL REIMBURSEMENT REQUEST FORM

Participant Information

Name: ______________________ ID Number: ______________________

Address: ______________________

Instructions: Complete the table on the reverse side of this form for eligible expenses incurred by you and/or your Dependents. **The minimum amount for medical reimbursement is $100.00.** Requests must be received by the Benefits Office no later than one year (12 months) following the date on which the expense was incurred. Please sign and date this form, then send it, along with your supporting documentation, to the Benefits Office at 1700 52nd Avenue, Ste. B, Moline, Illinois 61265 Attn: Claims Coordinator. Requests received by the Benefits Office on or before the last business day of the month will be processed the next month. If the participant is entitled to reimbursement under the rules and provisions of this Plan, the reimbursement will be issued on or about the fifteenth day of the month following the month in which the request was received. Requests submitted to the Benefits Office on a non-business day will be dated as being accepted on the next business day.

INFORMATION THAT MUST BE PROVIDED BEFORE MEDICAL REIMBURSEMENT WILL BE ISSUED

1. Completed Reimbursement Request Form.
2. Completed ACH form for Direct Deposit along with banking information, if not previously submitted or if you are updating your information.
3. All explanations of benefits (EOBs) from any health plans involved in paying medical expenses.
4. For those allowed claims that no EOB is generated (such as prescriptions and vision claims), documentation showing proof of payment or other evidence that qualified medical expenses incurred. For example, when you pick up a prescription, you receive a leaflet showing name of patient and dollar amount paid that is attached to the bag. This must be submitted or ask for a print out from your pharmacist. The documentation must include all required identifiers such as patient's name, date of service, description of item purchased, and dollar amount of purchase. Documentation does not include cash register receipts because they normally do not contain the required identifiers. No taxes or late fees are allowed to be reimbursed.
5. **If any part of this form is not completed properly and/or required documentation of Qualified Medical Expenses are not included, the form will be returned to the participant without reimbursement.**
6. **PLEASE USE THE REVERSE SIDE OF THIS FORM FOR MEDICAL REIMBURSEMENT REQUESTS.**

To the best of my knowledge and belief, my statements on this Form are complete and true. I certify all of the following: either my Dependent or I have received the services described on the reverse side of this form on the dates indicated and the expenses are my out-of-pocket expenses that qualify as valid qualified medical expenses under the Plan. I have not been reimbursed previously for these expenses under the Health Reimbursement Account Program. These expenses have not been reimbursed or are not reimbursable under any other source available for reimbursement (e.g. the Fund's health plan or any other health plan, such as my Spouse's plan). I understand that the expenses reimbursed may not be used to claim any federal income tax deduction or credit. I authorize a deduction in my Health Reimbursement Account in the amount of the reimbursement.

PARTICIPANT'S SIGNATURE: ______________________ **DATE:** ______________________