Phone (631) 694-2140
Fax (631) 694-7831

WELFARE FUND

INTERNATIONAL UNION OF OPERATING ENGINEERS
LOCAL UNIONS 138,138A, 138B & 138C Nassau & Suffolk Counties

P.O. BOX 206, FARMINGDALE, N.Y. 11735-0206

HEALTH REIMBURSEMENT ACCOUNT CLAIM FORM INSTRUCTIONS

What Expenses Can be Claimed

- Only expenses for services INCURRED during the plan year can be claimed for reimbursement.
- Expenses are incurred when you are provided the Health Care related service that gives rise to the expense and not when you are formally billed or charged for or pay for the expense.
- An expense must be qualifying as defined under Section 213(d) of the Internal Revenue Code. The expense must also be allowed under the Fund's provisions, because the Fund may restrict these expenses. Review the Fund's Summary Plan Description or contact the Fund Office for information related to eligible expenses.

How to Complete the Form

- When completing the Health Care expense section, list each claim expense separately on the form. **You cannot combine expenses that are listed on separate documents that may substantiate your expense. For example, if you have 30 prescription receipts, you must enter them as 30 separate claims on the form. However, if more than one eligible expense incurred on the same day is listed on one document, you may enter those expenses as one claim.**
- **You must make an entry for each expense incurred on a given date and provide supporting documentation.** Once you have listed all claims, total the amounts and list the total in the "Total Reimbursement Requested" box.
- Read the Health Care Expense Certification carefully; then sign and date the form.

Supporting Documentation

- Include photocopies of your supporting documentation to this claim form. Please DO NOT send original receipts.
- Supporting documentation must contain the following information:
  - Provider Name
  - Date the service was incurred
  - Recipient of the service
  - Description of the service provided
  - Expense amount
- Receipts for Over the Counter expenses that do not clearly identify the product being purchased must be accompanied by a copy of the box or container for each product in which you are requesting reimbursement.
- If any of these expenses were covered by insurance, attach a copy of the "Explanation of Benefits" from you insurance company as documentation.
- Cancelled checks and credit card statements/receipts are not considered valid supporting documentation. **The IRS has determined that canceled checks, check carbons, balance forward,**

Phone (631) 694-2140
Fax (631) 694-7831

WELFARE FUND

INTERNATIONAL UNION OF OPERATING ENGINEERS
LOCAL UNIONS 138,138A, 138B & 138C Nassau & Suffolk Counties AFL-CIO

P.O. BOX 206, FARMINGDALE, N.Y. 11735-0206

previous balance statements, charge card receipts or statements are not acceptable documentation of expenses. An Explanation of Benefits must be provided when available.

- Refer to the Summary Plan Description to determine whether your supporting documentation must be accompanied by a note from a physician stating the medical necessity of the expense.

HEALTH REIMBURSEMENT ARRANGEMENT CLAIM FORM

To request reimbursement, please complete this form, including appropriate documentation and provide signatures where required. **All required fields applicable to your claim must be completed in order to process the claim.**

I certify that all listed expenses have not been reimbursed by any other source, nor will they be reimbursed by any other source. In addition, I certify that these expenses were incurred for eligible members of my family or me, and they have not been reimbursed from any other health insurance coverage.

_____ _____
Participant's Signature Date

** REQUIRED - CLAIM CANNOT BE PROCESSED WITHOUT YOUR SIGNATURE **

Part 1: Participant Information:

Participant Name: (First) _____ (Last) _____

Social Security Number: _____ - _____ - _____ Phone: ( ) _____

Address: _____ _____ _____ _____
(Street) (City) (State) (Zip)

HEALTH REIMBURSEMENT ARRANGEMENT - (REQUIRED - COMPLETE ALL SECTIONS)

In order to receive reimbursement, copies of supporting documentation must be attached. Please include copies of an itemized bill from the provider listing exact dates of service (balance forward statements are not acceptable), service performed and cost or an Explanation of Benefits (EOB) from your insurance company listing service dates, service performed and cost. Please retain a copy of this claim form and supporting documentation for your records, as we are unable to return original documents to you.

Part 2. Itemized List of Expenses *continue on back if necessary

Service Date	Paid To	Drug Name if Prescription	Procedure Code	Amount

Phone (631) 694-2140
Fax (631) 694-7831

WELFARE FUND

INTERNATIONAL UNION OF OPERATING ENGINEERS
LOCAL UNIONS 138,138A, 138B & 138C Nassau & Suffolk Counties AFL-CIO
P.O. BOX 206, FARMINGDALE, N.Y. 11735-0206

Total Requested $ _____

PROCEDURE CODE
A = **Medical** B = **Dental** C = **Eye Care** D = **Prescription** E = **All Others**

FOR OF F ICE US E ONLY
Notified of ineligible expense Date _ _/ _ _/ _ _

Please Mail the completed, signed form along with copies of your medical charges to the address below:

HEALTH REIMBURSEMENT ARRANGEMENT CLAIM REQUEST FORM

Local 138, 138A, 138B & 138C
International Union of Operating Engineers Welfare Fund
P.O. Box 206
137 Gazza Boulevard
Farmingdale, NY 11735-0206