IBEW LOCAL NO. 150 WELFARE FUND

Return completed form to:
6525 Centurion Drive
Lansing, MI 48917
Toll Free: 877-478-4542

WELFARE REIMBURSEMENT ACCOUNT (WRA) CLAIM FORM

Name: (Please Print)		Date of Birth:	
Address:	City:	State:	Zip:
Member ID or SSN #:		Local Union #:	

REIMBURSEMENT REQUEST

For each medical, dental or vision reimbursement request, you must submit the following:

Explanation of benefits (EOB) for each medical/dental/vision expense submitted

For prescription drug reimbursement requests, you must submit an itemized receipt or printout from the pharmacy

If there is not enough in your account to cover the full amount requested, a check will be issued for the balance of your WRA account.

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 due date specified on your self-payment notice.

Total amount submitted from EOB's:	$
Total amount submitted from Prescription receipts	$
Total amount submitted for self-payments*: (*Self-payments refer to the payments that you make to continue your coverage with the Fund)	$
Total anticipated reimbursement:	$

I hereby certify that the expenses for which I am requesting reimbursement have been paid in full.

Signature: Date:

Telephone Number (Including area code):

Reimbursable Expenses

Calendar year deductible

Participant co-payments

Amounts in excess of any maximum benefits or limitations

Payment of otherwise covered medical expenses for work-related sicknesses or injuries which are excluded by the Fund

Payment of a self-payment or retiree premium for continued eligibility

Payment of expenses for medical, dental or vision services or for prescription drugs which are otherwise excluded under the Fund. The Trustees will determine which prescription drugs are reimbursable, subject to Federal Law.

Non-Reimbursable Expenses

Non-Prescription drugs, medicines and vitamins

Expenses for which reimbursement can be made by some other source

Expenses incurred that you (the employee) are not required to pay

Expenses for which reimbursement is not permitted under §213 of the Internal Revenue Code

Expenses not listed under "Reimbursable Expenses" above

Instructions

You may submit a request at any time, provided the request is received by the Fund Office no later than two years after the date the expenses was incurred. WRA payments are made weekly. If your request is received in the Fund Office by Tuesday, reimbursement will be made on Friday of the following week..

You must enclose:

Explanation of benefits (EOB) for each medical/dental/vision expense submitted

For prescription drug reimbursement requests, you must submit an itemized receipt or printout from the pharmacy

If you do not have enough in your account to cover the reimbursement you request, the Fund Office will pay the amount in your account. **You cannot resubmit a request for the unpaid balance.**

The minimum reimbursement request amount is $50. However, if you accumulate less than the $50 in reimbursable expenses during a calendar year, you may request reimbursement at the end of the year for the amount of reimbursable expenses you have accumulated.

Return this completed reimbursement request to the Fund Office