WISCONSIN ELECTRICAL EMPLOYEES HEALTH & WELFARE PLAN
2730 DAIRY DRIVE SUITE 101
MADISON WI 53718
(608) 276-9111 PHONE (608) 288-9103 FAX

FLEXIBLE BENEFIT ACCOUNT (FBA) CLAIM FORM

Participant Information:

Participant's Name _____ Plan ID Number _____

Address _____ City _____ State _____ Zip Code _____

FBA EXPENSE CLAIMS

Attach appropriate receipt(s) for each expense listed below when submitting the FBA Reimbursement form. **You must submit this form within 12 months of the date the claim was incurred. Requests for reimbursement must total a minimum of $100; however, the Plan permits participants to submit one reimbursement request in December of each year for less than $100.**

Along with this form, you must provide the following, as applicable:

- The number **ONE** and most important document we need is the Explanation of Benefits ("EOB") form sent to you by our office for medical services received by yourself or a member of your family and/or the EOB from any other insurance carrier other than this plan. An itemized bill for services for which you do not receive an EOB (vision expenses, dental expenses, prescription co-pays) may be submitted. These itemized bills must include the name of the person incurring the charges, date of service, description of service, name of provider and amount of charge.

- Proof of the amount and date paid when requesting reimbursement for other insurance premiums, such as a spouse's group health coverage premiums and verification that the premium was not paid or eligible for payment under an IRC section 125 Plan (you must submit a premium reimbursement form to verify the IRC 125 Plan information – Contact the Plan Office for a copy of this form).

- A receipt and proof of purchase or rental for covered items (such as for crutches or wheelchairs).

- Any additional documentation requested by the Plan.

It's a good idea to make a copy of all materials you submit for your records. Materials you submit will not be returned to you.

CLAIM SUBMISSION

Mail completed form and any required documentation to:

Wisconsin Electrical Employees
Health & Welfare Plan
2730 Dairy Drive Suite 101
Madison WI 53718

FBA Reimbursement forms are available on our website at www.weebf.com or www.weebf.org. You may also fax a copy of the completed form and documentation to 608-276-9103.

SIGNATURE REQUIRED ON BACK

FLEXIBLE BENEFIT ACCOUNT CLAIM FORM

Date Expense Incurred	Service Provider	Expense Description	Person for Whom Expense Incurred	Expense Amount
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
Total FBA Claims				$

PARTICIPANT'S AUTHORIZATION

By signing below, I certify that all services for which reimbursement is requested on this form were provided while I was eligible for coverage under the FBA portion of the Plan and were provided to me or my dependent(s) as defined under the Plan. Further, I certify that the eligible expenses have not been otherwise reimbursed, nor will they otherwise be reimbursed, through any other source, have not been paid (and could not have been paid) on a pre-tax basis, and have not been taken, nor intend to be taken, as a tax deduction. I understand that the Internal Revenue Code permits reimbursement only for eligible health care expenses, which means amounts paid for diagnosis, cure, mitigation, and treatment or prevention of disease. I understand that I alone am fully responsible for the sufficiency, accuracy, and truthfulness of all information relating to the claims on this form and that I am liable for payment of expenses and that if an expense is not eligible for reimbursement under the Plan's FBA, I am liable for payment of all related taxes on amounts paid by the Plan that relate to these expenses.

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Participant's Signature Date