

**UFCW Local 1776 and Participating Employers Health and Welfare Fund
Flexible Benefits Plan Claim Form**

Before completing this form, please read the information on the reverse side.

A. General Information

Participant's Name _____		Social Security No. _____	
Street Address _____	City _____	State _____	Zip Code _____
Employer _____	Store No. _____	Date of Hire _____	

- B. Request For**
- Dual Option Wrap-Around
 - Health Care Spending Account
 - Paid Time Off Benefit

(Participants who have used other coverage must complete this section to obtain reimbursement of their out-of-pocket costs under the health care spending and/or wrap-around provision.)

Name of policyholder _____
Address of policyholder _____
Name of carrier/carrier address _____
Policy Identification/Group ID No. _____

C. Summary of Medical Expenses Incurred

Participants who have incurred medical expenses and wish to be reimbursed must complete this section.

<u>Patient's Name</u>	<u>Patient's Date of Birth</u>	<u>Date of Service</u>	<u>Type of Service</u>	<u>Amount</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

(Attach itemized bills in accordance with the instructions in Section C on the reverse side.)

I hereby certify that the above expenses have not been reimbursed to me, my spouse or dependents under any group health or other insurance plan, program or arrangement that covers me, my spouse, or dependents, or by any other third party.

Participant's Signature _____ Date _____

D. Paid Time Off

\$ _____ Hourly Rate

- Full Time Employee
- Part Time Employee

Work schedule _____
Amount being requested _____

E. Release of Information All participant's must complete Section E.

I hereby authorize any health care provider or insurance carrier to disclose/release information necessary to process this Flexible Benefits Claim form.

Participant's Signature _____ Date _____
Phone number (include area code) Home _____ Work _____

Instructions for Submitting a Claim Form Under the Flexible Benefit Plan

This claim form must be completed if you are requesting reimbursement of (1) medical out-of-pocket expenses under the Dual Income Option Wrap-Around provision, (2) Health Care Spending Account, or (3) if you are requesting payment for Paid Time Off.

Section A General Information. All participants must complete this portion of the claim form.

Section B From what benefit program are you requesting reimbursement? Check the appropriate box. Information regarding "other insurance" must be completed if you are requesting reimbursement of medical expenses or out-of-pocket expenses under the Dual Income Option Wrap-Around or Health Care Spending accounts.

Section C In this section of the claim form, list medical expenses for which you are requesting reimbursement. After you incur medical expenses for you or your eligible dependents which cannot be reimbursed from any other source, you must submit itemized bills and an Explanation of Benefits form from the "other" insurance carrier. Itemized bills include:

Name and address of provider	Patient's full name
Date of service	Type of service provided
Amount billed for each service	Amount paid by patient

Important - bills missing any of the above information will not be processed. The Fund cannot accept cash register receipts, cancelled checks, "balance due" statements or money order receipts in place of itemized bills. Please be sure all bills are legible.

Section D If you are requesting Paid Time Off benefit reimbursement, complete this portion of the claim form. List your "normal or usual" work schedule, work status (full- or part-time employee), hourly wage, and amount being requested.

Section E All participants must READ, then sign and date this portion of the claim form. Please list your telephone number so that, if necessary, we can contact you for additional information.

Please make copies of all bills and insurance vouchers for your own records. Originals will not be returned to you. Mail the completed claim form and itemized bills to:

UFCW Local 1776 and Participating Employers Health and Welfare Fund
3031 B Walton Road
Plymouth Meeting, PA 19462
Attn: Flexible Benefits Program

If you have any questions about this claim form or need assistance in completing this form, contact the Fund office at (610) 941-9400 or toll free at 1-800-458-8618. Visit our website at www.ufcw1776benefitfunds.org