

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 19426
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