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

IMPORTANT! *Please read the information on the reverse side of this form before completing.*

A. General Information *(ALL participants must complete this section)*

_____ XXX-XX-_____
Participant's Name — Social Security No. *(last 4 digits only)*

_____
Street Address — City — State — Zip Code

_____
Employer Name — Store No. — Date of Hire

B. Release of Information Authorization Statement *(ALL participants must complete this section)*

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

Participant Signature: _____ **Date:** _____
Phone Number *(including area code)*: **Home:** _____ **Work:** _____

C. I Am Requesting Reimbursement From: *(Check all that apply)*

- ☐ Dual Income Option *(complete section "D" below)*
- ☐ Flexible Spending Account *(complete section "E" below)*
- ☐ Paid Time-Off Bank *(complete section "F" below)*

If you are requesting reimbursement for eligible medical expenses under the Dual Income Option and/ or from your Flexible Spending Account, you MUST provide information regarding your other insurance coverage AND certify that the expenses listed in sections "D" and/or "E" have not been reimbursed to you:

Name/Address of policyholder: _____
Name/Address of Carrier: _____
Policy Identification/Group ID No.: _____

Certification Statement: I hereby certify that the expenses listed in sections "D" and/or "E" below have not been reimbursed to me, my spouse, or dependents, under any other group health or insurance plan, program, or arrangement that covers me, my spouse, or my dependents by any other third party.

Participant Signature: _____ **Date:** _____

D. Dual Income Option - Summary of Medical Expenses Incurred *(Participants who have incurred eligible medical expenses and are requesting reimbursement under the Dual Income Option must complete this section).*

Patient's Name	Patient's Date of Birth	Date of Service	Type of Service	EOB Enclosed? (*yes/no*)	Itemized Bill Enclosed? (*yes/no*)	Reimbursement Request Amount
						$
						$
						$

*If additional room is needed, you **MUST** attach and submit **a** list of the additional expenses in chart format, as shown above.*

E. Flexible Spending Account - Summary of Medical Expenses Incurred *(Participants who have incurred eligible medical expenses and are requesting reimbursement from the Flexible Spending Account must complete this section).*

Patient's Name	Patient's Date of Birth	Date of Service	Type of Service	EOB Enclosed? (*yes/no*)	Itemized Bill Enclosed? (*yes/no*)	Reimbursement Request Amount
						$
						$
						$

*If additional room is needed, you **MUST** attach and submit a list of the additional expenses in chart format, as shown above.*

F. Paid Time-Off Bank *(Participants requesting payment from their Paid Time-Off Bank must complete this section).*

Hourly Rate	Full-time or Part-time Employee? (*FT/PT*)	Work Schedule	Requested Amount
$			$

UFCW LOCAL 1776 AND PARTICIPATING EMPLOYERS HEALTH AND WELFARE FUND

INSTRUCTIONS FOR SUBMITTING THE FLEXIBLE BENEFITS PLAN CLAIM FORM

This claim form must be completed if you are requesting out-of-pocket medical expense reimbursement (1) under the Dual Income Option, (2) from your Flexible Spending Account, and/or (3) if you are requesting payment from your Paid Time-Off Bank.

Section A: General Information

All participants must complete this section of the claim form in order for the claim to be processed.

Section B: Release of Information Authorization

All participants must READ, then sign and date the Authorization Statement in order for the claim to be processed. Please list your telephone number so that, if necessary, the Fund Office can contact you for additional information.

Section C: I Am Requesting Reimbursement For:

All participants must complete this section of the claim form in order for the claim to be processed. From what benefit program(s) are you requesting reimbursement? Check the applicable box(es). If you are requesting reimbursement for eligible medical expenses under the Dual Income Option and/ or from your Flexible Spending Account, in this section, you MUST also (1) provide information regarding your other insurance coverage, and (2) READ, then sign and date the Certification Statement, which certifies that the expenses you list in sections "D" and/or "E" have not been reimbursed to you, your spouse, or your dependents. If you are requesting payment from your Paid Time-Off Bank benefit only, simply check the appropriate box, and then skip to section "F".

Section D: Dual Income Option – Summary of Medical Expenses Incurred

If you are requesting reimbursement under the Dual Income Option, complete the chart in this section of the claim form. List each expense for which you are requesting reimbursement, including the following information: the patient's name, the patient's date of birth, date that the service was incurred, the type of service that was incurred, confirmation as to whether you have enclosed an itemized bill and Explanation of Benefits ("EOB") statement for the expense, and the amount for which you are requesting reimbursement. If additional room is needed, you MUST attach and submit a list of your expenses in the same chart format.
This claim will NOT be processed without an itemized bill and EOB submitted for each expense listed. Please refer to the "IMPORTANT!" note below for more detailed instructions as to the itemized bill and EOB statement requirements.

Section E: Flexible Spending Account – Summary of Medical Expenses Incurred

If you are requesting reimbursement from your Flexible Spending Account, complete the chart in this section of the claim form. List each expense for which you are requesting reimbursement, including the following information: the patient's name, the patient's date of birth, date that the service was incurred, the type of service that was incurred, confirmation as to whether you have enclosed an itemized bill and Explanation of Benefits ("EOB") statement for the expense, and the amount for which you are requesting reimbursement. If additional room is needed, you MUST attach and submit a list of your expenses in the same chart format.
This claim will NOT be processed without an itemized bill and EOB submitted for each expense listed. Please refer to the "IMPORTANT!" note below for more detailed instructions as to the itemized bill and EOB statement requirements.

IMPORTANT!

In order for this claim to be processed, for each expense listed in sections "D" and "E", you MUST submit (1) an itemized bill from the health care provider, AND (2) an Explanation of Benefits ("EOB") statement.

Itemized bills MUST include:

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

You may be able to obtain an EOB from:

- Your insurance provider
- Your health care provider

Please note that the Fund Office will NOT accept bills or EOB's that are illegible, or cash register receipts, canceled checks, "balance due" statements, or money order receipts in place of itemized bills. It is YOUR responsibility to submit these items in order for the claim to be processed. Please make copies of all bills and EOB's for your own records. Originals will not be returned to you.

Section F: Paid Time-Off Bank

If you are requesting payment from your Paid Time-Off Bank benefit, complete this section of the claim form. List your hourly rate, your work status (if you are full-time, mark "FT", or if you are part-time, mark "PT"), your "normal" or "usual" work schedule, and the amount you are requesting. Please note that you can only request payment from your Paid Time-Off Bank on a quarterly basis.

Once complete, mail the form, along with itemized bills and EOB's, to the Fund Office at:

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

If you have any questions about your Flexible Benefits, 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, or visit www.ufcw1776benefitfunds.org.