

IBEW Local Union No. 22/NECA Health & Welfare Fund Health Reimbursement Arrangement (HRA) Claim Form

Email address

Address

Employee

City

Employer Name

State, Zip

Date of Birth

Phone

THIS FORM SHOULD BE COPIED FOR FUTURE USE

Please attach the Explanation of Benefits (EOB) in the order you have it listed below and fill in with dates of service, description, and claim total, then sign and date below and mail or fax to *Wilson-McShane Corporation*. **All valid forms of documentation must include the following: Date(s) of Service, Type of Expense, Amount Applied to the Deductible and the Name of the Service Provider. See back of this form for a description of valid forms of documentation.**

NOTE: Cancelled Checks or credit card receipts/statements or Provider statements are not valid forms of documentation.

List each EOB separately

Date(s) of Service	Description	Dollar Amount
1.		\$
2.		\$
3.		\$
4.		\$
5.		\$
6.		\$
7.		\$
Claim Total:		\$

This is to certify that my statements on this Claim Form are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for my eligible dependents. I certify that these expenses have not been, nor will be reimbursed under this or any other benefit plan and will not be claimed as an income tax deduction. I authorize my HRA to be reduced by the amount requested.

Signature: X

Date:

Reminders

Provide an EOB(s) for all expenses submitted.

Minimum check amount is \$50.00.

Sign and date the Reimbursement Form.

Keep copies of everything submitted.

Wilson-McShane Corporation cannot process an unsigned form.

IRS guidelines require that Wilson-McShane Corporation keep records of all claims and correspondence for three years. Multiple expenses may be included on one form. If more space is needed, attach additional forms.

Mail completed forms to:

Wilson-McShane Corporation,

8960 "L" Street, Omaha, Nebraska, 68127
Telephone: (402) 593-7565 / (877) 762-9348

Fax: (402) 593-7609