# CLAIM FOR REIMBURSEMENT
# HEALTH AND WELFARE TRUST FUND EXTENDED RESERVE ACCOUNT

Name ______________________________________________ Social Security #____________________

Street Address _________________________________________

City, State, Zip Code_____________________________________

**Complete only the sections that apply to the claim you are submitting for reimbursement. Part 1 is for Unreimbursed Medical Expenses and Dependent Care Expenses, Part 2 is for Authorization to Deduct Self Payment Amounts from your Extended Reserve Account to continue coverage. Payment for Medical Reimbursement will be issued to you once a month, provided you have a balance in your Extended Reserve Account.**

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**Part 1: UNREIMBURSED MEDICAL EXPENSES AND DEPENDENT CARE CLAIMS-** Send Bills, Explanation of Benefits or other documents. The dependent care bill should list the provider's Social Security Number or Tax ID Number.

| Date Incurred | Name of Service Provider | Expense Description | Person for Whom Expense Incurred | Net Amount |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | TOTAL AMOUNT CLAIMED: | |

**PLEASE READ CAREFULLY:**

The undersigned participant in the plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form are for covered medical expenses. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including Federal, State or City Income Tax on amounts paid from the Plan which relate to such expense. It is the member's responsibility to keep copies of all claim forms and receipts for potential IRS Audits.

**The undersigned certifies that the above Medical expenses have not been reimbursed and are not reimbursable under any other health plan coverage.**

_____________________________________________ _____________________________________

**Employee's Signature** **Date**

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## PART 2: AUTHORIZATION TO DEDUCT SELF PAY PREMIUM FROM EXTENDED RESERVE ACCOUNT

My signature below is authorization to have the monthly premium amount required for Active Member self payment, Retiree Premium or COBRA coverage to be deducted from my Extended Reserve Account. I understand that payment deduction from my Extended Reserve will continue only under the terms of the U. A. Local 467 Health and Welfare Trust Fund rules of Self Payment and COBRA coverage. The authorization is for continuation of coverage as checked below. I may continue Medical Only Coverage or Medical and Dental Coverage. I may not continue Dental Only coverage.

***Please check only one option:***
I elect deduction of the required Medical Only Coverage: _____________
I elect deduction of the required premium for Medical and Dental Coverage: _____________

This authorization will remain in effect until the earliest of the following; a) such time as I am no longer eligible to continue coverage under the self pay rules or COBRA coverage, b) my Extended Reserve Account balance is exhausted or c) I rescind the authorization in writing. I understand if I rescind this authorization prior to the end of the period allowed by self pay rules, I can not later elect to use the Extended Reserve Account for any remainder of that entire period.

__________________________________________ _____________________________

**Employee's Signature** **Date**

Send Completed Claim Form to:

**United Administrative Service**
**467 EXTENDED RESERVE**
**P.O. Box 5057**
**6800 Santa Teresa Blvd. Ste. 100**
**San Jose, Ca 95119**