Utility Workers' Union of America
National Health & Welfare Fund
Administered by Wilson-McShane Corporation

3001 Metro Drive - Suite 500
Bloomington, MN 55425

Toll Free: (800) 920-8116
Fax: (952) 851-3569

Name:____________________________ **Social Security #** ____________________
PLEASE PRINT

Address: ____________________________ **Telephone Number:**____________________
PLEASE PRINT PLEASE INCLUDE AREA CODE

City, State, Zip____________________________ **Email Address:** ____________________

____ Please check here if this is a new address

Instructions for claims submission:
For each itemized bill, receipt or explanation of benefits (EOB), please provide the date of service, a description of what it represents, the amount of reimbursement being requested, and the individual for whom reimbursement is being requested.

For whom may I request reimbursement?
The Health Reimbursement Account limits expenses to the employee covered by the collective bargaining agreement (or participation agreement) and their eligible dependents as defined in the IRS Code § 152.

Total reimbursement requested must exceed $50.00. Please attach itemized bills/receipts/EOB's for each family member you are seeking reimbursement for allowable medical expenses. Please itemize your expenses below and attach receipts in order. **NOTE: Bills/receipts must clearly indicate the patient name, physician name, date of service, etc. In addition, if your bill/receipt is for a co-payment, this must be clearly indicated on your bill/receipt.**

-Missing information may cause a delay in the processing of your claim(s)-

	Service Date	Description of Charges	Provider Name	Amount	Patient Name	Relationship
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
		Total				

I certify that the claims itemized above have not otherwise been reimbursed and are not reimbursable through any other source. Further, I certify that Health FSA (flexible spending account established through payroll deduction) coverage, if any, for such expenses has been exhausted. I also certify that the expenses itemized are being submitted for myself and/or my eligible dependents and represent allowable expenses as defined within the Summary Plan Description **(please read the reverse side of this form).**

____________________________ ____________________
Signature of Participant Date

Medical Care Expenses: In general, medical care expenses include, but are not limited to, amounts for such things as hospitalization, doctors and dentists bills, and prescription drugs. Such expenses also include amounts you pay for deductibles, co-payments, coinsurance, as well as premiums for group health plan coverage (provided premiums are not paid through salary reduction contributions under the terms of a Code Section 125 plan or any plan that provides for premium payment with pre-tax dollars), COBRA continuation coverage, and Medicare Parts B, C, and D coverage. However, not all medical care expenses will be considered "eligible health care expenses" that qualify for reimbursement under the Plan. Generally, only medical care expenses within the meaning of Section 213 of the Internal Revenue Code are eligible. Some Section 213 medical expenses are excluded from coverage (see "Excludable Expenses" below.) If you have any questions as to whether an expense is reimbursable, call the Plan Administrator.

Excludable Expenses

*The following expenses are not reimbursabl*e, even if they meet the definition of "medical care" under Code Section 213 and may otherwise be reimbursable under IRS guidance pertaining to HRAs:

- Long-term care services.
- Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. "Cosmetic surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.
- Over-the-counter medications without a prescription.
- The salary or expense of a nurse to care for a healthy newborn at home.
- Funeral and burial expenses.
- Household and domestic help (even though recommended by a qualified physician due to a participant's or dependent's inability to perform physical housework).
- Massage therapy.
- Home or automobile improvements.
- Custodial care.
- Costs for sending a problem child to a special school for benefits that the child may receive from the course of study and disciplinary methods.
- Health club or fitness program dues, even if the program is necessary to alleviate a specific medical condition such as obesity.
- Social activities, such as dance lessons (even though recommended by a physician for general health improvement).
- Bottled water.
- Diaper service or diapers.
- Cosmetics, toiletries, toothpaste, etc.
- Vitamins and food supplements, even if prescribed by a physician.
- Uniforms or special clothing, such as maternity clothing.
- Automobile insurance premiums.
- Transportation expenses of any sort, including transportation expenses to receive medical care.
- Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.
- Any item that does not constitute "medical care" as defined under Internal Revenue Code § 213.
- Premiums paid through salary reduction contributions under the terms of a Code Section 125 plan or any plan that provides for premium payment with pre-tax dollars.

Claims Submission:

A claim for reimbursement for an eligible health expense must be submitted to the Plan Administrator within 12 months of the date the expense was incurred. After 12 months, the expense will no longer be eligible for reimbursement.

Please return completed form and supporting documents to:
UWUA National Health & Welfare Fund
Attn: Claims Department
3001 Metro Drive, Suite 500
Bloomington, MN 55425

Fax: (952) 851-3569
Email: claims@wilson-mcshane.com