IBEW LOCAL UNION NO. 22/NECA
HEALTH and WELFARE TRUST FUND

Health Reimbursement Arrangement (HRA) Claim Form

(Please see the reverse side for instructions in preparing and submitting this form)

Completed forms with proper documentation (referenced below) should be returned to:
IBEW Local Union No. 22/NECA Health and Welfare Fund
Attn: HRA Department
8960 L Street
Suite 101
Omaha, Nebraska 68127
flex@zenith-american.com
Fax: (402) 951-9500

For questions regarding your account balance, the status of claim payments, eligible expenses or how to file a claim on-line, log onto the mobile app Zenith East Coast, email flex@zenith-american.com, or call the Fund Office at (402) 592-3753.

Participant Information (Please print legibly):

Name (Last, First, M.I.)	Social Security Number
Address (Street, City, State, Zip)	Daytime Telephone

Allowable Medical Care Expense Information Please complete all of the information for each expense listed below. You must also attach supporting documentation for each expense (an itemized bill for dental and vison, Explanation of Benefits (EOB) of all medical expenses, receipt for prescription expenses, or proof of premium payment). **It is a good idea to make a copy of all materials you submit for your records**.

NOTE: Cancelled Checks or credit card receipts/statements are not valid forms of documentation. The reimbursement form must be signed and dated as unsigned forms will not be processed.

List each expense separately

Date(s) Expense Incurred	Name of Service Provider	Expense Description	Person for whom Expense was Incurred/Relationship to Member	Reimbursement Amount Requested from HRA
				$
				$
				$
				$
				$
			Total Reimbursement from HRA :	$

I certify that my statements on this claim form are complete and true. I certify that any expenses reimbursed are for Allowable Medical Care Expenses for myself or my Dependent(s) and such expenses have not and will not be reimbursed by any other source or entity, nor be claimed as an income tax deduction.

_____ _____

Signature Date

Important Information:

- You must sign and date this form
- Claims must be received by the Fund Office by June 30 of the calendar year following the calendar year in which the expense was incurred.
- If the claim is for prescribed over-the-counter medicine, you must submit one of the following items with your claim for reimbursement:
    - A receipt from a pharmacy which identifies the name of the purchase (or name of the person for whom the prescription applies), the date and amount of the purchase, and an Rx number; or
    - A receipt from a pharmacy without an Rx number accompanied by a copy of the related prescription.
- Keep copies of everything submitted
- If you have other insurance coverage that is secondary to this Plan, your claim must be filed with your secondary carrier before your claim for reimbursement is processed. You must submit a copy of the secondary carrier's Explanation of Benefits (EOB) with your claim for reimbursement.
- For premiums or self-payment toward coverage under the IBEW LOCAL UNION NO. 22/NECA (COBRA or Retiree)--complete the form **above** with the requested information and include a copy of your self-pay coupon (sent monthly). The HRA department will verify internally within the Trust Office confirmation of your COBRA or retiree payment. If you are filing a claim for a COBRA payment made to a different Plan (not the IBEW LOCAL UNION NO. 22/NECA), you must include a signed and dated letter from the other Plan which contains the following information:
    a. Name of insured
    b. Name of dependents covered
    c. Amount paid
    d. Month of coverage paid for
- I you are making a self-payment to cover premiums for IBEW LOCAL UNION NO. 22/NECA (COBRA or Retiree) that payment will be made directly to the IBEW LOCAL UNION NO. 22/NECA (COBRA or Retiree) Health Plan on your behalf.