SOLANO-NAPA COUNTIES ELECTRICAL WORKERS HEALTH AND WELFARE PLAN
KAISER DEDUCTIBLE AND COINSURANCE REIMBURSEMENT CLAIM FORM

INSTRUCTIONS: Expenses incurred for the Kaiser medical deductible, coinsurance and copayment amounts are reimbursable. **The Plan will only reimburse a maximum of $3,000 per individual to a maximum of $6,000 per family per calendar year**. Complete this form and submit it along with a copy of your Kaiser bill or Summary of Account (SOA) /Explanation of Benefits (EOB) and proof of payment. Please be sure that all documents reflect the patient's name, description of service, dates of service and the amounts.

A separate Form must be completed for each Patient (e.g., one for yourself, your spouse, and each dependent child).

Participant Information	
Name:	**Last 4 Digits Social Security Number:** XXX-XX-_____
Mailing Address:	
Contact Phone Number:	**Email Address:**

Patient Information

Patient Name: _____

Relationship to Participant (Check Box):

☐ Self ☐ Dependent Spouse ☐ Dependent Child Child's Date of Birth _____

List expenses below and include copies of supporting document(s) with this Form.

Date of Service (MM/DD/YY)	**Provider's Name** (Dr. Name/Office Name)	**Amount of Claim** (Reimbursement Amount)

By signing this form, I understand that benefits shall be paid in accordance with the Kaiser Deductible, Coinsurance and Copay Reimbursement Program eligibility requirements and limitations established by the Board of Trustees.

Participant's Signature: _____ **Date:** _____

If you have questions, contact NWPS at 855-512-1170.

Return the completed Claim Form and supporting document(s) by mail, fax, or email:

Mail: NWPS
160 W. Santa Clara Street, Suite 1550
San Jose, CA 95113-1734

Fax: 408-298-1180

E-mail: sncewrp@nwpsbenefits.com