Canton Electrical Welfare Fund

P.O. Box 1129 Troy, MI 48099-1129 Toll Free: 1-800-435-2388
Email: flexclaims@benesys.com Fax: 1-248-556-2597

AUTHORIZATION FOR DISBURSEMENT FROM YOUR HRA ACCOUNT

Instructions: To receive reimbursement from the Health Reimbursement Arrangement ("HRA"), you must complete ONE FORM per patient, along with the following information:

Reimbursement for:	Information Required – please attach:
Medical Co-Payments	**Copy of your EOB (Explanation of Benefits Form)** *Balance due statements are not acceptable*
Dental Co-Payments	**Copy of Itemized bill** *Orthodontics will be paid for after services are rendered*
Vision Co-Payments	**Copy of Itemized bill**
Prescription Co-Payments	**Copy of the drug label stub or a printout from your pharmacy** *Cash register receipts are not acceptable.*

PLEASE NOTE: You MUST allow up to 30 business days for reimbursement. All reimbursements for claims will be made payable to the member.

Member's Name:_____ Member SSN: xxx-xx-_____

Address:_____

_____

Telephone:_____

Patient Name:_____ Relationship:_____

I am requesting payment for the following charges for which I have not been reimbursed, and for which I have not and will not claim a federal income tax deduction.

Type of Service Medical/Dental/Vision/Rx	Provider's Name	Date of Service	Amount of Claim

****Please make a copy for yourself of all charges submitted in the event of loss****

By signing this form, I understand that benefits shall be paid in accordance with my Health Reimbursement Arrangement's eligibility requirements and limitations established by the Board of Trustees.

Member's Signature:_____ Date:_____
Not Valid Unless signed and dated by Member

MAIL TO: Canton Electrical Welfare Fund HRA
P.O. Box 1129, Troy, MI 48099-1129
FAX: 1-248-556-2597 or EMAIL: flexclaims@benesys.com

What do I have to do to request reimbursement for my benefit?
You must send a completed Reimbursement Claim Form along with the following information attached:

Reimbursement for:	**Information Required**
Medical Reimbursement	A copy of the Explanation of Benefits form (EOB) from your medical carrier showing the member's responsibility and matches the amount being requested below, and receipts showing payment was made for expenses not covered by the Health and Welfare Plan. Unreimbursed medical, dental, vision, and prescription expenses are subject to limitations specified in your Summary Plan Description. ***(Please note: Balance due statements are not acceptable.)***
Dental/Vision Claims	Attach a copy of the itemized billing. This billing must include the date of service, procedure code for services performed, and the patient's name. **Orthodontic services will be paid once services are rendered.**
Self-Payment	Attach a copy of the self-payment notice.

Where do I obtain Reimbursement Claim Forms?
You may print the Reimbursement Claim Form from the **Participant Website at https://www.ourbenefitoffice.com/IBEW540/Benefits**

Click on Documents, select Health Care – Health Care Documents, select Medical Reimbursement Form. You may also contact the Fund Office at (800) 435-2388 to have a claim form mailed to you.

Where do I send my reimbursement requests?
You have (3) options to submit your claim(s).

By MAIL:	**By FAX:**	**By EMAIL:**
Canton Electrical Welfare Fund PO Box 1129 Troy, MI 48099-1129	Fax: (248) 556-2597	e-mail: **flexclaims@benesys.com**

Is there a time limit to file for reimbursement benefits?
Yes, reimbursement benefit claims must be filed within one year from the date the services were rendered.

NOTE: Dental/vision claims must be filed within one year from the date of service.

What information should I keep?
Please keep a copy of all items submitted in case of an audit or IRS documentation request.