Limited Health Care Flexible Spending Account

• Please fax this signed and completed form to: (925) 297-6655
• For Customer Service, please call: (855) 617-2478

1. Participant Information and Signature

By submitting this claim form, I (participant named below) request reimbursement from my Limited Health Flexible Care Spending Account as listed below. I agree to the Terms and Conditions stated below; I certify and warrant to IBEW/Western Utilities Health & Welfare Fund that these are eligible **Dental** and/or **Vision** expenses that my dependents or I have incurred.

Participant Name (please print): _____ Social Security Number: _____

Participant Address (complete only if address has changed): _____
Street City State Zip

How may we contact you during the day? E-Mail: _____ Phone:_____

Participant Signature: _____Date: _____

3. Dental/Vision Reimbursement

List each receipt separately. Use additional forms if necessary. **Use the provider certification space below only if no receipt is attached.**

Patient Name	Provider Name	Description of Service	Date Service Provided	Requested Amount

***Provider Certification/Verification*:** I certify that the Dental and Vision expenses listed above were incurred by the participant named above.

***Provider Address*:** Street:_____ City:_____ State:_____ Zip:_____

***Provider Signature*:**_____ **Date:**_____

4. Terms and Conditions

I (above-named participant) understand and agree that:

- These Dental and Vision expenses are not reimbursable from any other health plan, insurance, or other source, and will not be used to claim any federal income tax deduction or credit.
- I am responsible for any inappropriate use or disclosure of my information that occurs due to my selected method of transmitting this information (e.g., fax, e-mail, or any other media).
- I authorize the Plan and its service provider (IBEW/Western Utilities Health & Welfare Fund), their respective agents, employees, subcontractors, and assigns to use and/or disclose the information provided above as they reasonably deem necessary to manage the Plan (including but not limited to, disclosures to my employer for Plan administration purposes, such as the evaluation of eligibility for reimbursement under the Plan) and to detect or prevent fraud or misrepresentation.
- I give up any claims related to the use, disclosure, or release of this information so long as the information is used for the purposes defined above.
- This authorization does not in any way limit any right that IBEW/Western Utilities Health & Welfare Fund, their respective agents, employees, subcontractors, and/or any assigns may have under applicable state or federal law or regulation regarding the use of such information.

Submitting Your Completed Form:

• **Fax** completed Request for Reimbursement forms to**:** 1-925-297-6655 **Member Services:** 1-855-617-2478

NOTE: ***Use discretion when faxing your personal medical information. You bear full responsibility for any inappropriate use or disclosure that may arise in connection with your transmission of information to IBEW/Western Utilities Health & Welfare Fund.***

OR

• **Mail** completed claim form to:

IBEW/Western Utilities Health & Welfare Fund
P.O. Box 99416
Troy, MI 48099

Rvsd 08/17/2022