WISCONSIN ELECTRICAL EMPLOYEES' HEALTH AND WELFARE PLAN
2730 DAIRY DRIVE SUITE 101
MADISON WI 53718
(608) 276-9111 OR (800) 422-2128
FAX (608) 276-9103

PARTICIPANT NAME PLAN ID NUMBER

FLEXIBLE BENEFIT ACCOUNT (FBA) CLAIM FORM:

You can now file your Flexible Benefit Reimbursement Claim form directly from the WEEBF website at www.weebf.com by logging in under your username and password, select the FSA Account tab on the dashboard.

Flexible Benefit Reimbursement requests must be received by the Fund Office no later than one year (twelve months) following the date on which the expense was incurred. Request for reimbursement must total a minimum of $100, however, the Plan permits participants to submit one reimbursement request in December of each year for less than $100.00.

Attach the Explanation of Benefits (EOB) that you wish to file for reimbursement. If there is a secondary insurance carrier on you, or any eligible dependent, you must submit that secondary insurance carrier's EOB to show your final out of pocket balance for which you are filing for.

Attach prescription co-pays or a print-out from your Pharmacy. A Doctor's prescription must be submitted with any over the counter medicine, supplies, creams, vitamins etc. before any reimbursement can be made from your flex account.

Any durable medical equipment rental or purchase (crutches, wheelchairs, walkers etc.) **OR** charges that are NOT eligible under your Health and Welfare Plan, will require an itemized bill from the Provider with proof of payment unless processed through the insurance which then generates an EOB under your claim history records.

Orthodontic treatment must be initiated and braces in place before claims can be filed either under the insurance or for reimbursement out of your flex account, however, if you submit a signed Orthodontic contract with proof of full payment you can collect your out-of-pocket amount from your flexible reimbursement account in advanced.

If submitting reimbursement for a spouse's group health coverage premium, you must complete two (2) forms, 1) The Employer Verification Form for Health Insurance Premium Expenses (Employer to complete); and 2) Form for Employees Seeking Reimbursement of Health Insurance Premiums (Employee to complete) along with proof of payment. Contact the Fund Office for the forms or you can print them off from the website at www.weebf.com under the Health and Welfare link.

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Date Expense Incurred	Service Provider	Expense Description OR Claim Number	Patient Name	Out-Of-Pocket Amount Request
		TOTAL FLEX REIMBURSEMENT REQUEST	**$**	

If this Flex Reimbursement request is for MORE than the amount in my Flex Account, I AUTHORIZE the Plan to issue the remaining balance from my Flex Account towards this FBA payment request. I understand I cannot collect on any out-of-pocket expenses submitted on the explanation of benefits that were over and above my Flex account balance at later date because it falls under the Plan's exclusion for partial flex reimbursement payments.

By signing below, I certify that all services for which reimbursement is requested on this form were provided while I was eligible for coverage under the FBA portion of the Plan and were provided to me or my dependent(s) as defined under the Plan. Further, I certify that the eligible expenses have **NOT** been otherwise reimbursed, nor will they otherwise be reimbursed, through any other source, have not been paid (and could not have been paid) on a pre-tax basis, and have not been taken, nor intend to be taken, as a tax deduction. I understand that the Internal Revenue Code permits reimbursement only for eligible health care expenses, which means amounts paid for diagnosis, cure, mitigation, and treatment or prevention of disease. I understand that I alone am fully responsible for the sufficiency, accuracy, and truthfulness of all information relating to the claims on this form and that I am liable for payment of expenses and that if an expense is NOT eligible for reimbursement under the Plan's FBA, I am liable for payment of all related taxes on amounts paid by the Plan that relate to these expenses.

Participant Signature   Date