

**WISCONSIN ELECTRICAL EMPLOYEES HEALTH AND WELFARE PLAN**  
**2730 DAIRY DRIVE SUITE 101**  
**MADISON WI 53718**  
**(608) 276-9111 PHONE (608) 276-9103 FAX**

**FLEXIBLE BENEFIT ACCOUNT (FBA) CLAIM FORM**

**PARTICIPANT INFORMATION:**

---

Participant Name:	Plan ID Number
-------------------	----------------

---

Address	City	State	Zip
---------	------	-------	-----

---

**FBA EXPENSE CLAIMS**

Attached appropriate receipt(s) for each expense listed below when submitting the FBA Reimbursement form. Flexible Benefit reimbursement requests can be submitted to the Plan at anytime, however, such requests **MUST BE RECEIVED by the Fund Office no later than one year (twelve months) following the date on which the expense was incurred.** Requests 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.

Along with this form, you **MUST** provide the following, as applicable:

- The number **ONE** and most important document we need is the Explanation of Benefits (“EOB”) form sent to you by our office for medical services received by yourself or a member of your family **and/or the EOB from any other insurance carrier other than this plan (including any Medical Assistance Program).** An itemized bill that includes the name of the person incurring the charges, date of service, description of service, name of provider and amount of charge is required if no EOB was received (i.e...prescription co-pays).
- Proof of the amount and date paid when requesting reimbursement for other insurance premiums, such as a spouse’s group health coverage premiums and verification that the premium was not paid or eligible for payment under an IRC section 125 Plan (you must submit a premium reimbursement form to verify the IRC 125 Plan information – Contact the Plan Office for a copy of this form).
- A receipt and proof of purchase or rental for covered items (such as for crutches, wheelchairs, walkers etc...).
- Any additional documentation requested by the Plan.

It’s a good idea to make a copy of all materials you submit for your records. Material’s you submit will not be returned to you. Mail completed form and any required documentation to:

**WISCONSIN ELECTRICAL EMPLOYEES BENEFIT FUND**  
**2730 DAIRY DRIVE SUITE 101**  
**MADISON WI 53718**

FBA Reimbursement forms are available on our website at [www.weebf.com](http://www.weebf.com) or [www.weebf.org](http://www.weebf.org). You may also fax a copy of the completed form and documentation to 608-276-9103.

**SIGNATURE REQUIRED ON BACK**

# FLEXIBLE BENEFIT ACCOUNT CLAIM FORM

[illegible]

**Yes / No** I do not have enough monies in my Flex Account to pay this Reimbursement request in full and wish for you to pay out the balance in my Flex Account towards this FBA request. I understand I cannot collect on any out-of-pocket expenses submitted with this form that were over and above my Flex account balance at a later date as this 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.

Participants Signature

Date \_\_\_\_\_