WISCONSIN ELECTRICAL EMPLOYEES HEALTH AND WELFARE PLAN FLEXIBLE BENEFIT ACCOUNT PROGRAM

EMPLOYER VERIFICATION FORM FOR HEALTH INSURANCE PREMIUM EXPENSES

*Name of Employee				
*Name of Employer and Address The above named Employee is enrolled for coverage under the following plans:				
Health Plan				
Dental Plan				
Vision Plan				
Prescription Drug Plan				
Other (List other health care coverages)				
Check one:	V - VI			
☐ The Employer does no insurance premiums on a				
☐ The Employer mainta may pay for health insur			vhich employees	
Contact Person and Telephone Number For Above Named Employer		Telephone Number		
Signature of Contact Person		Date		
By signing below, I give the permission to contact the E about my health plan cover	Employer named above	for additional infor	and Welfare Plan mation, if required,	
Employee Signature		D	Date	
Employee's Relationship to Health and Welfare Plan:	Participant Enrolled i	n Wisconsin Electri	cal Employees	

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FORM FOR EMPLOYEES SEEKING REIMBURSEMENT OF HEALTH INSURANCE PREMIUMS

	Item I	Item 2
Coverage Period of Health Plan for Requested Reimbursement		
Name of Persons Covered Under Health Plan and Relationship to You	Self Spouse Dependent	Self Spouse Dependent
Total Amount Of Expense		
Amount Reimbursed Previously or Payable Under Another Plan		
Amount of Reimbursement Requested		

<u>Documentation Required</u>: You must submit an invoice or other statement from the insurance carrier or your spouse's Employer which states the premium amount, verifies that coverage was in effect during the period for which reimbursement is requested and verifies that no portion of the premium could have been paid pre-tax under a section 125 cafeteria plan. Attach Employer Verification Form for Health Insurance Premium Expenses if you are requesting a reimbursement for your spouse's health insurance premiums.

<u>Certification</u>: To the best of my knowledge and belief, my statements in this Form are complete and true. I certify all of the following:

- If the Premium Expense is for my Spouse or Dependent, the person listed is my spouse or dependent as defined under Internal Revenue Code section 152 without regard to subsections (b)(1), (b)(2) and (d)(1)(B).
- I have not been reimbursed previously for these Premium Expenses under the Flexible Benefits Account Program.
- The Premium Expenses have not been reimbursed and are not reimbursable under any other health plan, such as under a plan of my spouse's employer.
- No portion of the Premium Expenses could have been paid pre-tax under another employer's Code section 125 cafeteria plan. (See attached Employer Verification Form for Premium Expenses.)
- I understand that the Premium Expenses reimbursed may not be used to claim any federal income tax deduction or credit.

I authorize a deduction in my Flexible Benefit Account in the amount of the reimbursement

Participant Signature	Date