Reimbursement Request Form

Employer Name: UA Local 13

Participant Name (First, MI, Last): _____

Social Security Number: _____ - _____ - _____

Address: _____

City, ST, ZIP: _____

Date of Birth: _____/_____/_____ Phone Number (_____) _____

Please notify your employer of any address change. Lifetime Benefit Solutions will not make address changes from this form.

Claimant Name	Relationship to Member	Date of Service	Amount	Type of Service/Item Purchased	Plan Code*	Claim Ref #
John Sample	*son*	*5/1/2021*	*$ 25.00*	*Doctor visit copay*	*HB*	*Example*
			$			01
			$			02
			$			03
			$			04
			$			05
			$			06
			$			07
			$			08
			$			09

Use the Plan Code below.

*Plan Code	Plan Code Description
HB	Hours Bank Reimbursement

By submitting this form to Lifetime Benefit Solutions, I certify the information is accurate, the expenses incurred were for myself, spouse or qualified dependents, and these expenses are not reimbursable under any other plan coverage. In addition, I have read the Reimbursement Request Instructions on the following page and agree to adhere to all terms specified. I understand if I do not follow the instructions my reimbursement may be delayed or denied.

- **Mail to:** Lifetime Benefit Solutions, Claims Dept, PO Box 211126, Eagan, MN 55121 or
- **Fax to:** 877-256-7228.
- Call **Customer Service** with questions at 800-327-7130.

*****PLEASE REFER TO THE BACK OF THIS PAGE FOR REIMBURSEMENT REQUEST INSTRUCTIONS*****

Reimbursement Request Instructions

Hours Bank Reimbursement Submission Guidelines

- If you are submitting expenses under another insurance plan, you must submit an Explanation of Benefits (EOB) statement.
- All dental expenses must include an Explanation of Benefits (EOB)
- Claims must include:
  - Name of service provider
  - Date of service
  - Description of services rendered
  - Amount charged
  - Name of person who received the services
  - Proof of Payment
- Submit one expense (either a product or service) per row, even if items are contained on the same Health Statement or bill.
- Label each statement/bill with the corresponding Claim Ref # from the claim form. This will assist with matching the statement to the claim.
- If you have more items than the form can accept, use additional forms.
- Do not "lump" or group items together or write See Attached.
- All claims are subject to deadlines, as defined in your Summary Plan Description (SPD).
- The expenses you submit must qualify as valid expenses under the terms of the Plan, and the claimant receiving the services must be a qualifying individual as defined in the Plan.
- Lifetime Benefit Solutions can only process claims that are properly submitted. Claims that are not properly submitted may be delayed or denied.
- Retain a copy of the Reimbursement Request Form and statements for your own personal records;
- Call Lifetime Benefit Solutions Customer Service with questions at (800) 327-7130 during standard week-day business hours.
- Mail OR fax (but not both!) completed form with required documentation to:

  Lifetime Benefit Solutions Claims Dept.
  PO Box 211126
  Eagan MN 55121
  Fax # (877) 256-7228

***Please be aware that once you receive reimbursement it is your responsibility to pay the provider directly.**