NWSMW VEBA Plan Reimbursement Claim Form

Phone: (509) 534-0600 | Toll Free: (800) 872-8979 | Fax: (509) 535-7883
Email: nwsmw@rehnonline.com | Website: www.nwsmwbenefits.com
Post Office Box 5433 | Spokane, WA 99205

Participant Name | **Account ID or SSN** | **Date of Birth**

Mailing Address ☐ Check here if new | **City** | **State** | **Zip**

Email Address ☐ Check here if new | **Phone** ☐ Check here if new

SECTION A: REIMBURSEMENT REQUEST

Date of Service	Name of Service Provider	Expense Description	Person Incurring Expense	Person Incurring Expense Social Security Number	Person Incurring Expense Date of Birth	Amount

SECTION B: INSURANCE PREMIUM REIMBURSEMENT REQUEST

Name of Insurance Company	Monthly Premium Amount	Number of Months Paid	Total

NOTE: Premiums paid by an employer or through a pre-tax Section 125 Cafeteria Plan are not eligible for reimbursement.

TOTAL AMOUNT OF REIMBURSEMENT

☐ If there are insufficient funds in my account to reimburse me for the entire claim submission, by checking this box I authorize the Administrator to automatically use future contributions to reimburse me for the remainder of this claim.

Total Amount of Reimbursement For **Section A:** _____

Total Amount of Reimbursement For **Section B:** _____

Total Amount To Be Reimbursed: _____

SIGNATURE

READ CAREFULLY: I hereby certify that (1) the information provided in this claim request is true and correct; (2) the amount of the submitted claim to the Third-party Administrator is an accurate statement of my unreimbursed medical/dental/vision expenses and/or medical/dental/vision/tax-qualified long-term care insurance premiums; and (3) the submitted claim is not reimbursable from any other source. With respect to claims submitted on behalf of qualified dependents, I hereby certify that such person meets the Plan requirements as summarized on the reverse side and is a qualified dependent as defined under the terms of the Plan. With respect to claims for qualified insurance premiums, I hereby certify that such premiums have not been paid by my employer and are not eligible for pre-tax deduction through my or my spouse's Section 125 Cafeteria Plan.

Signature of Plan Participant | **Date**

~ Instructions For Filling Out The Claim Form Are On The Reverse Side ~

ALL CLAIMS MUST BE SUBMITTED TO INSURANCE PRIOR TO BEING REIMBURSED FROM THE VEBA PLAN

INSTRUCTIONS FOR SUBMITTING CLAIM FORM

Use this form to request reimbursement of qualified healthcare expenses and/or insurance premiums you have incurred on behalf of yourself, your spouse, and/or your eligible dependents. Qualified expenses and premiums submitted for reimbursement must have been incurred after you became a participant eligible to file claims and after insurance has processed your eligible expenses.

If this claim reimbursement request is an eligible benefit/expense through your medical/dental/vision insurance plan, please submit the claim to them for processing, prior to seeking reimbursement through the VEBA Plan.

HOW TO EXPEDITE YOUR CLAIM

1. **Fully complete all requested information**. Missing information may delay the processing of your claim and could result in your claim being denied. Do not forget to sign and date the form.
2. Email your claim to nwsmw@rehnonline.com
3. You must attach detailed itemized verification for each expense or service. Verification should contain (1) patient (covered individual) name; (2) date the item was purchased or service was provided; (3) description of expense or service; and (4) out-of-pocket amount. Acceptable forms of verification include (1) an explanation of benefits (EOB) from the insurance; (2) a detailed itemized billing or statement from your provider; or (3) a detailed receipt for prescription or over-the-counter (OTC) medications. Cancelled checks and balance forward statements are **NOT** acceptable.

   NOTE: Please do not use a highlighter on your expense receipts. If you want to identify certain items on your receipts, circle the items with a regular pen instead. Highlighting often appears illegible on faxes and electronic imaging equipment to process your claim.
4. For qualified insurance premium reimbursement, you must attach documentation which includes the following; (1) name(s) of covered individual(s); (2) premium amount(s); (3) policy period; and (4) insurance provider name and address. This information is typically contained on your premium billing notice. NOTE: Premiums paid by an employer, or premiums that are or could be deducted pre-tax through your or your spouse's employer, are not eligible for reimbursement. If you request reimbursement of after-tax premiums deducted from your (or your spouse's) paycheck, you should include a letter from the employer which confirms that a pre-tax option for the payment of such premiums is not available.

QUALIFIED EXPENSES AND PREMIUMS

Internal Revenue Code 213(d) defines qualified expenses and premiums, in part, as "medical care" amounts paid by insurance "for the diagnosis, cure, mitigation, treatment, or prevention of disease…" Expenses solely for cosmetic reasons generally are not eligible (e.g. facelifts, hair transplant, hair removal, etc.).

Common expenses include co-pays, coinsurance, deductibles, and prescriptions. Common insurance premiums include medical, dental, vision, tax qualified long-term care (subject to IRS limits), Medicare Part B, Medicare Part D, and Medicare supplement plans. COBRA payments and Self-pay payments are reimbursable as well. Please note the following:

1. Insurance premiums paid by an employer or premiums that are, or could be deducted pre-tax through you or your spouse's section 125 cafeteria plan, are not eligible for reimbursement.
2. If you or your spouse has a section 125 healthcare flexible spending account (FSA), you must exhaust the FSA benefits before submitting claims.
3. Claims for over-the-counter (OTC) medicines and drugs should be for reasonable quantities expected to be consumed within a reasonable period of time. Sales tax can be included. As of January 1, 2011 all OTC items deemed as a DRUG or MEDICINE will now require a prescription or letter of medical justification from your doctor.

ELIGIBLE DEPENDENTS

A dependent of the plan participant includes their spouse and/or a son, daughter, stepchild or foster child who, as of the end of the calendar year in which the expense was incurred, will be age 26 or younger or who is permanently disabled. Please see Internal Revenue Code Section 105(b) for more information.