FLEXIBLE BENEFIT ACCOUNT REIMBURSEMENT REQUEST FORM

Return Completed Form to:
NECA IBEW Local No. 364 Health & Welfare Fund
Flexible Benefit Account
6525 Centurion Drive
Lansing, MI 48917

Participant's Name _____Member ID or SS#_____

Home Address_____
Street City State Zip Code

Telephone Number _____Date of Birth_____

Enclosed claims are for (check only one) ☐ Self ☐ Spouse ☐ Son ☐ Daughter

Dependent's Name _____ Date of Birth_____

Is dependent covered by another health insurance plan? ☐ Yes ☐ No

When Filing Claims

1. **Supporting documentation must accompany this Request Form. Supporting documentation includes any of the following:**

   - **Explanation of Benefit Form(s) indicating deductible, co-insurance and any amounts not paid from any Medical, Dental or Vision Plans under which you and/or any of your eligible dependents are covered.**

   - **Itemized bills from doctor, dentist or other supplier for recognized medical expenses not covered by your Medical/Dental/Vision Plans.**

2. **Retain copies of supporting documentation for your records, as those submitted will not be returned.**

3. **Send completed Reimbursement Request Form and supporting documentation to the Fund Office at the address above.**

I certify that either myself and/or my eligible dependents have incurred the expenses for which reimbursement is claimed from the Flexible Benefit Account.

_____ _____
Employee's Signature **Date**