SPOUSAL OTHER INSURANCE PREMIUM REIMBURSEMENT REQUEST FORM

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

Participant's Name ______________________________ **ID# or SS#** ____________________

Home Address ____
Complete Physical Street Address

Telephone Number ______________________________

Enclosed reimbursement request is for:

Spouse's Name ____

Name of Other Insurance ____

Month to be Reimbursed ________________ **Amount of requested reimbursement** ______________

When Filing Claims

1. **You must send completed Spousal Other Insurance Premium Reimbursement Request Form and supporting documentation to Fund Office at the address above. Supporting documentation includes either of the following:**

   - **A letter from your spouse's employer indicating the amount of the monthly premium for health care coverage. This letter will be required each month before reimbursement will be made.**

   - **Copies of your spouse's paycheck check reflecting the payroll deduction for health insurance. You must provide copies of the paycheck for each payroll period, for each month that you are requesting reimbursement.**

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

I certify that my spouse has incurred the insurance expense for which reimbursement is claimed from the Spousal Other Insurance Premium Reimbursement Account. (This form is available online at www.ibew364benefits.org, click on Health & Welfare and then Forms.)

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Employee's Signature **Date**

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Spouse's Signature **Date**

Fund Office Use Only

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Amount Reimbursed	**Reference Number**	**Processed by**