



Phone (706) 937-9600

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### SPECIAL FUND ACCOUNT REIMBURSEMENT REQUEST FORM

- Type or print information (items 1 through 8) on the Employee Section below. Only one patient can be listed on a request form. However, more than one provider can be listed for that one patient.
- Enter total amount for which claim is being made in the appropriate sections. A minimum of \$50 should be accumulated before you submit a claim.
- Supporting documentation must accompany this request form. Supporting documentation includes the following:
  - Explanation of Benefit Statement(s) indicating deductibles, co-insurance, co-payment or amounts in excess of usual and customary charges from any medical/dental plan(s) under which you and/or any of your eligible dependents are covered, or if the expense is not covered under your medical/dental plan, itemized bills from doctors, dentists or other suppliers for insured expenses.
- Retain copies of supporting documentation for your records.
- Send completed claim form and supporting documentation, in a personal and confidential envelope, to the Administrative Office at the address above.

**NOTE: ANY ITEMS FOR WHICH YOU ARE REIMBURSED CANNOT BE CLAIMED AS DEDUCTIONS OR CREDITS ON YOUR FEDERAL INCOME TAX RETURNS.**

1. Employee's Name	2. Soc. Sec. No.	3. Address
4. Patient's Name	5. Relationship	6. Local Union
7. Provider Name(s)	8. I have medical coverage through the NECA/IBEW Family Medical Care Plan: yes <input type="checkbox"/> no <input type="checkbox"/>	

#### UNREIMBURSED HEALTH CARE EXPENSES

	Date of Service	Claim Amount to be Reimbursed
Medical/Dental/Vision	_____	\$ _____
Other	_____	\$ _____
COBRA/Self Pay	_____	\$ _____
	Total \$	\$ _____ (\$50 minimum)

I certify that either I and/or my eligible dependents have incurred the expenses for which reimbursement is claimed from the Special Fund Account and I further declare that I have not and will not deduct these expenses on my individual income tax returns. No assignment will be accepted.

Employee Signature \_\_\_\_\_

Date \_\_\_\_\_

