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NECA FMCP IBEW
Family Medical Care Plan

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SPECIAL FUND ACCOUNT
SELF-PAYMENT OR REIMBURSEMENT REQUEST FORM

1. Type or print information (items 1 through 8) on the Employee Section below. Only **one patient** can be listed on a request form. However, **claims from more than one provider can be attached for that one patient.**
2. Enter total amount for which claim is being made in the appropriate sections.
3. **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.
4. Retain copies of supporting documentation for your records.
5. 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** [Choose]	**6. Local Union**	
7. Provider Name(s)	**8. I have medical coverage through the NECA/IBEW Family Medical Care Plan: yes ☐ no ☐**		

PLEASE APPLY FUNDS FROM MY SPECIAL FUND ACCOUNT:

_____ *Reimburse per attached supporting documentation in the amount of $_____.
_____ Apply this amount towards COBRA payment for the month of [Choose if applicable].
_____ Self-Payment Amount for the month of [Choose if applicable] in the amount of $_____.
WEX balance $_____. (office use only)
_____ I authorize funds from my Special Fund Account to be automatically deducted toward any future short hour self-pay. I acknowledge that such automatic deductions will occur and are non-refundable unless and until I withdraw this authorization in writing and it is received by the Administrative Office.

***Unless otherwise notified by you, the participant, the benefit that will be paid will be the maximum benefit based on the EOBs/Itemized Statements you submitted and your account balance.**

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 declare that I have not and will not deduct these expenses on my individual income tax returns. I further certify that I and/or my eligible dependents have not submitted the expenses listed above for reimbursement to any other health reimbursement account (HRA), flexible spending account (FSA), or health savings account (HSA). No assignment will be accepted.

Employee Signature Date