TUCKPOINTERS LOCAL 52 HEALTH AND WELFARE FUND

Flex/Health Spending Account Reimbursement Request

MEDICAL_____RX _____ VISION _____

- Complete and sign this form **(*original Member signature is required)***.
- Attach an **itemized** receipt from the ophthalmologist, optometrist or other supplier, which identifies the person receiving the service. **Keep a copy of your receipts for your records. (*The originals you submit will not be returned).***
- A copy of our **E**xplanation **of B**enefits or denial explanation is required for all medical expenses.
- If other insurance, an Explanation of Benefits or denial from them must be submitted with your claim.
- Send the completed Flex form and other materials to: (Faxed copies not accepted)

Tuckpointers Local 52 H&W
660 Industrial Drive, Suite 201
Elmhurst, IL 60126

Member's Name: _____Social Security #: XXX-XX_____

Member's Address: _____

_____

Telephone Number: ( ) _____

Patient: Self: _____ Spouse _____ Dependent: _____Social Security #_____ -_____ -_____(Required)

Dependent Name: _____ Relationship: _____ Date of Birth: _____/_____/____

Date(s) of Service: _____/_____/_____ to _____/_____/_____

Describe Service performed: (Exam, Rx, glasses, contacts, braces etc.)
_____

_____

Required: I Do _____ I Do NOT _____ (have other insurance that covers the expenses submitted)

I certify that either I and/or my eligible dependents have incurred the expenses for which the reimbursement is claimed from the Flex/Health Spending Account Benefit or I further declare that I have not and will not deduct these expenses on my individual Income Tax Returns. Any misrepresentation or fraudulent statement by a claimant constitutes grounds for denial of all the benefits for the claimant and dependents, or the cancellation or recovery of benefit payments made in reliance thereon. **No assignment will be accepted. All payments will be made to the Member.**

Member's Signature: _____Date: _____

For Benefits Office use only

Claim # _____ Amount $_____ Processed _____/_____/_____ By _____

OVER

**** DEADLINE APRIL 1ST - NO EXCEPTIONS****

PLEASE NOTE:

- You must submit your **complete** claim no later than April 1st of the year following the year in which the expense was incurred.
- Expenses that may be reimbursed are those expenses you or your Eligible dependent(s) have which are not covered or not paid by any other portion of the Tuckpointers Local 52 Health and Welfare Fund nor any other plan including Public Aid.
- Reimbursement based on Eligibility at time of service under the Tuckpointers Local 52 Health and Welfare Plan.
- Fill out one (1) form for *each person* **per type of service** (Medical, RX, Vision).
- Do not combine bill types.
- Organize receipts in date order. For RX claims, you may submit the computer printouts supplied by local Pharmacy, or Express Scripts. Please tape the small store receipts to a separate piece of paper.
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- All Rx claims submitted must show the amount the plan paid.
- Please note – if you or any of your dependents have Public Aid/County Care they are **Primary** for your Vision claims.
- Any mail orders for contacts/glasses **must** include patient name, eye glass prescription, proof of delivery and payment**.**
- Claim forms submitted with *missing information or incomplete* documents will be returned.

**** DEADLINE APRIL 1ST - NO EXCEPTIONS****