Unified Fire Authority VEBA Trust

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VEBA ACCOUNT 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, more than one provider can be listed for that one patient.
2. Enter the total amount for which the claim is being made in the appropriate sections. A minimum of $25 should be accumulated before you submit a claim.
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, or a billing statement for coverage from you insurance carrier.
4. Retain copies of supporting documentation for your records.
5. Mail, fax, or email the completed claim form and supporting documentation to the Administrative Office at the address above or numbers listed above. If sending by mail please use a secure personal and confidential envelope.

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. (last four digits)	3. Address
4. Patient's Name	5. Relationship	
6. Provider Name(s)		

UNREIMBURSED HEALTH CARE EXPENSES

	Date of Service	Claim Amount to be Reimbursed
Deductible		$
Coinsurance / Co-payments		$
Insurance Premiums		$
	Total	$

I certify that either I and/or my eligible dependents have Incurred the expenses for which reimbursement is claimed from the VEBA Trust 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