Mo-Kan WBA Reimbursement Claim Form

Name: ____

Mo-Kan ID Number: ____

Home address: ____

Phone Number: ____

Un-reimbursed Medical Expense Claims – Please sort by year of the date of service and patient on each form.

Date Expense Incurred	Name of Service Provider	Expense Description	Patient Name	Dollar Amount being Requested

Total Medical Care Expense: $ _____________

Attach Itemized Bills & Receipts and/or EOBs

Read Carefully -

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the Wellness Reimbursement Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts from the Plan which relate to such expense.

Please Note -

Over-the-counter medications – (Starting 1/1/2011, most will require a doctor's prescription for reimbursement) Expenses are generally reimbursable unless used for general well-being or for purely cosmetic purposes.

For a complete listing of WBA Reimbursable Expenses, please visit our website at www.mokansheetmetal.org.

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Participant's Signature Date

Fax or mail completed forms and copies of itemized bills, receipts or EOBs to:

Mo-Kan Sheet Metal Workers Welfare Fund

P.O. Box 300019

Kansas City, MO 64130-0019

Fax: 816-753-7252 Phone: 816-531-0334 Toll Free: 1-866-531-5488