IRONWORKERS LOCAL UNION NO. 383 HEALTH CARE PLAN

Health Reimbursement Election Form

I, _____ , hereby elect to have the Fund Office reimburse
(Please Print Name)
me from my Health Reimbursement account for the following expenses (check all that apply):

- ☐ Plan-related expenses, including deductibles and percentage coinsurance/copayments applied to my annual out-of-pocket maximum. It is not necessary to submit itemized receipts for deductibles or out-of-pocket maximums. All other reimbursement requests require itemized receipts.

- ☐ Medical, vision, dental, and prescription drug expenses incurred when I was eligible under the Plan. Must include itemized receipts.

If your spouse and/or dependents are eligible for other coverage, you also must submit EOBs from the other plan showing its payment.

I understand it is my responsibility to submit expense documentation on all medical, vision, dental, and prescription drug expenses along with this Reimbursement Election Form. Reimbursements will be processed within 30 days from received date.

By signing this form, I attest that I, my spouse, or my dependents incurred the expenses for which I am requesting reimbursement and that these expenses have not been reimbursed and are not eligible to be reimbursed by any other source, nor have we taken a tax deduction for these expenses.

_____ _____
(Signature of Participant) (Date)

_____ _____
(ID Number) (Phone Number)

The available amount you are requesting to be taken out of Health Reimbursement Account.

$_____.

Please return to: 2901 West Beltline Highway, Suite 100, Madison, WI 53713

Phone: 608-278-9500 / 800-497-4766 Fax: 608-278-9505