Reset Form

Local 434 Health & Welfare Fund
Dollar Bank Reimbursement Program Claim Form

Participant Name:_____ ID #: _____

☐ Check this box if you wish to be reimbursed for Plan-related expenses, including deductibles and percentage copayments applied to your annual out-of-pocket limit. (It is not necessary to submit itemized receipts for deductibles or copayments.)

List other expenses for which you are requesting reimbursement:

Prescription drug copayments and all other reimbursement requests require itemized receipts. Itemized receipts must include date of service, name of patient, name and address of provider, description of the expense, and dollar amount of the expense. We cannot pay from balance due statements. Claims for over-the-counter drugs must include an adequate receipt that states the name of the drug, the date, and the amount paid. If your supermarket or pharmacy receipt does not include this information, you will need to copy the label from the product or its packaging, circle the correct amount on your receipt, and submit this information with a properly completed dollar bank reimbursement request form.

If an expense requires a doctor's written order or other documentation, please include this with your request. If your spouse and/or dependents are eligible for other coverage, you also must submit Explanation of Benefits (EOBs) from the other plan showing its payment.

Date of Service	***Name of Patient***	***Name and Address of Service Provider***	***Expense Description***	***Dollar Amount***
If additional space is needed, please attach a separate sheet of paper.			***Total***	$
			If you do not want your total reimbursement to exceed a maximum amount, please list that amount here:	$

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Read Carefully: *By signing below, I hereby elect to have the Fund Office reimburse me from my dollar bank account for the listed expenses. I attest that I, or my dependents, incurred the expenses for which I am requesting reimbursement. I certify that all services for which reimbursement or payment is claimed by submission of this form have not and will not be reimbursed under any other health plan coverage or any other source. I acknowledge that this reimbursement will reduce the dollar bank contributions available to maintain Plan eligibility and waive all rights and claims that I and my dependents have relating to these dollar bank contributions.*

The Internal Revenue Code permits reimbursement only for medical care, which means amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body. I understand that I alone am fully responsible for the sufficiency, accuracy, and truthfulness of all information relating to this claim which is provided by me, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, I may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense.

Participant's Signature	*Date*

Mail claim form and receipts to:
Local 434 Health & Welfare Fund
Wilson-McShane Corporation
3001 Metro Drive, Suite 500
Bloomington, MN 55425
Phone: (952) 854-0795 / (800) 535-6373/ Fax: (952) 851-3521