



Claim Form for Medical/Dental/Vision Expenses or Premiums

Please type or print in black ink. You may fill in and print out this form online at www.veba.org

1. INSTRUCTIONS FOR FILING CLAIMS FOR BENEFITS

Please follow steps 1 – 5 below.

Please list only one person on each claim form. You can use photocopies of this form, or you may download and print claim forms at www.veba.org. Only claims for expenses or premiums incurred subsequent to participant's membership effective date may be submitted.

Step 1. Complete section 2. (To speed processing, please answer all applicable questions.)

Step 2. Complete all of sections 3 and/or 4, and section 5.

Step 3. Attach **itemized** verification for each expense or service item listed on this claim. You must provide either: an Explanation of Benefits (EOB); itemized billing or itemized statement from your provider; or a detailed receipt for prescription or over-the-counter medications.

Step 4. Sign and date the back of the form in section 6.

Step 5. Mail, fax, or e-mail this completed form and itemized claim verification to the third-party administrator (TPA). See reverse side for contact information.

2. CLAIMANT

Please print clearly. Check here if this is a change of address.

Your Name: _____ SSN or Account No.: _____
(Plan Participant)

Home Address: _____ City: _____

State: _____ Zip Code: _____ Home Phone: _____ Employer: _____

Work Phone: _____ E-mail Address: _____

Complete if claim is for a spouse/dependent. This is a (check one): Spouse Claim Dependent Claim

Name of spouse/dependent: _____ Date of Birth: _____

Relationship to plan participant: _____

Eligible dependents are defined by Internal Revenue Code Section 105(b) and outlined in IRS Publication 502. Individuals can qualify as your dependent under this plan if they are a "qualifying child" or "qualifying relative" for the year in which the expense is incurred. A "qualifying child" is an individual who: lives with you for more than half the year and does not provide more than half of his/her own support; will be under age 19 or age 24 (if a full-time student), or is permanently and totally disabled on the last day of the current year; is a citizen national, or resident of the U.S. or a resident of Canada or Mexico; and is your child, step-child, foster child, sibling, step-sibling, or a descendent of these individuals. A "qualifying relative" is an individual who: does not provide more than half of his/her own support; is not a qualifying child of yours or any other taxpayer; is a citizen national, or resident of the U.S. or a resident of Canada or Mexico; and has a specified onship to you, or lived with you all year as a member of your household.

3. EXPENSES

If your claim includes qualified health care expenses you must complete this section.

Please attach verification of your listed claims. You may summarize multiple dates of service in a similar category, such as prescriptions, but all the receipts must be attached. If you or your spouse are a current participant in a Section 125 Health Care Flexible Spending Account (FSA), you must exhaust the FSA benefits before filing an eligible VEBA claim.

| Date(s) of Service: | Provider of Service(s): | Description of Service(s) Rendered: | Total Out-of-Pocket: |
|--|-------------------------|-------------------------------------|----------------------|
| _____ | _____ | _____ | \$ _____ |
| _____ | _____ | _____ | \$ _____ |
| _____ | _____ | _____ | \$ _____ |
| _____ | _____ | _____ | \$ _____ |
| _____ | _____ | _____ | \$ _____ |
| _____ | _____ | _____ | \$ _____ |
| _____ | _____ | _____ | \$ _____ |
| _____ | _____ | _____ | \$ _____ |
| Total out-of-pocket expenses to be reimbursed from your account: | | | \$ _____ |

If more space is needed, please attach an additional sheet of paper. For additional claim forms, it is OK to use photocopies of this form. You can also download and print forms at www.veba.org or call 1-800-VEBA101 (832-2101) or (509) 534-0600.

4. PREMIUMS

If your claim includes qualified insurance premiums you must complete this section. Please attach verification of payment of premiums. If you are requesting reimbursement of long-term care premiums, you must attach verification of the premium amount and that the policy is tax-qualified. Long-term care premium reimbursements are also subject to annual IRS limits.

| Name of Insurance Company | Premium Amount | List Months Paid | Total Paid |
|--|----------------|------------------|------------|
| _____ | \$ _____ | _____ | \$ _____ |
| _____ | \$ _____ | _____ | \$ _____ |
| _____ | \$ _____ | _____ | \$ _____ |
| _____ | \$ _____ | _____ | \$ _____ |
| _____ | \$ _____ | _____ | \$ _____ |
| Total premiums to be reimbursed from your account: | | | \$ _____ |

Note: Premiums paid by an employer, or premiums that are or could be deducted pre-tax through your or your spouse's Section 125 cafeteria plan, are not eligible for reimbursement.

5. SUMMARY

| | |
|--|----------|
| Total reimbursement for qualified health care expenses (from Section 3) and/or | \$ _____ |
| Total reimbursement for qualified insurance premiums (from Section 4) | \$ _____ |
| Total to be reimbursed from your account: | \$ _____ |

6. SIGNATURE

I hereby certify that: the information provided in this claim request is true and correct; the amount of this submitted claim to the TPA is an accurate statement of my unreimbursed medical/dental/vision expenses and/or medical/dental/vision/tax-qualified long-term care insurance premiums; and the submitted claim is not reimbursable from any other source. With respect to claims submitted on behalf of qualified dependents, I hereby certify that: such person meets the Plan requirements as summarized in section 2; and is a qualified dependent as defined under the terms of the Plan. With respect to qualified insurance premiums submitted in section 4, I hereby certify that: such premiums have not been paid by my employer; and are not eligible for pre-tax deduction through my or my spouse's Section 125 cafeteria plan.

Signature of Plan Participant

Signed this _____ day of _____, _____.

Please keep a copy of this form for your records. You may mail, fax, or e-mail this form and claim verification to the TPA.

VEBA Trust
Third-party Administrator
REHN & ASSOCIATES
 P.O. Box 5433, Spokane, WA 99205-0433
 Fax: (509) 535-7883
 E-mail: veba@rehnonline.com

| |
|---|
| Did you... <input type="checkbox"/> Complete ALL applicable sections? <input type="checkbox"/> Attach required verification for each section? <input type="checkbox"/> Sign this form? |
|---|

The Trustees, TPA, and your employer do not guarantee any tax results or particular tax treatment regarding the taxation of benefits provided by this Plan.

Qualified claims are any unreimbursed medical, dental, or vision expenses defined by Internal Revenue Code Section 213(d) which are incurred by you, your spouse, or qualified dependents. Qualified premiums include payments for medical, dental, vision, or tax-qualified long-term care insurance. A list of qualified expenses may be viewed on our website.

If your account is allocated among multiple investment funds, withdrawals will be made pro-rata based on your current account balance in each fund, unless you request otherwise.

If you have any questions about your account or a pending claim, or need claim forms, please visit www.veba.org, call the TPA toll-free at 1-800-VEBA101 (832-2101), or e-mail: veba@rehnonline.com.

Please be sure to notify us by phone, mail, or e-mail of any address change.