



# IBEW Local No. 236

## Health and Benefit Fund, Annuity Fund, and Pension Fund

William J. McDaniel, C.P.A.

### IBEW LOCAL 236 HEALTH & BENEFIT FUND APPLICATION

Claims under this benefit must be submitted within (12) months from the date the expense was incurred and must total at least \$100.00 (several bills may be added together to reach this). Please allow 2-3 weeks for processing checks over \$1,500.00. A \$400.00 minimum for a 2-party check.

**YOU CANNOT REDUCE YOUR ACCOUNT BELOW THE APPLICABLE MINIMUM LEVEL**  
**Minimum balances effective January 1, 2009 are \$5,700 for single, \$11,000 for 2-person and \$13,700 for families.**

Name of Participant: \_\_\_\_\_  
 SS#: \_\_\_\_\_

**SUPPORTING EVIDENCE THAT MUST BE SUBMITTED:** Provider (i.e. doctor, dentist, pharmacy), itemized statements showing individual, service and payment info; original receipts; prescription and co-pay receipts with legible descriptions; cancelled check copies (front & back). No register tapes, etc.

*Those items immediately reimbursable are as follows:*

|   |  |
|---|--|
| \$ _____ (5100) Medical co-pays and deductibles     | \$ _____ (5110) Prescript. drug co-pays    |
| \$ _____ (5120) Dental self-paid receipts           | \$ _____ (5150) Optical self-paid receipts |
| \$ _____ (5130) Self-paid health insurance premiums | \$ _____ (5170) Other                      |
| \$ _____ (5160) Work Shoes                          | \$ _____ (5140) Large Ticket Items         |

**TOTAL AMOUNT APPLIED FOR \$ \_\_\_\_\_**

**GUIDELINES – PART I**

**Before submitting your reimbursement to the Fund office for those items not already listed above or covered in the normal course of health insurance coverage, the following must be completed and proof provided:**

**A. From the Health Insurance Carrier:**

- Benefit claim for the item/service must be submitted to your Health Insurance carrier
- Explanation of benefits (EOB) from the carrier

**Where applicable:**

- A denial letter from insurance carrier stating item/service is not allowed and reason(s) denied
- A properly documented appeal petition of the denial submitted to insurance carrier
- Denial of appeal from insurance carrier stating reason(s) for denial. You may submit any Health Insurance cost or health related expenses **NOT** covered by your insurance carrier that *qualify as reimbursable/deductible by the Internal Revenue Service*. Cosmetic surgery is **NOT** considered health related, and is not covered under this Plan.
- *Submission for pre-approval of allowability for any large dollar items is strongly advised.*

**B. This application must be signed by the participant acknowledging the following statement:**

**I certify that I have submitted all the required documents necessary to submit a claim to my Health Insurance and I have no other carrier(s).**

Signature of Participant: \_\_\_\_\_ Date: \_\_\_\_\_

**FOR OFFICE USE ONLY**

Processed by: \_\_\_\_\_ Amount Paid: \$ \_\_\_\_\_ Pulled file: \_\_\_\_\_ 2<sup>nd</sup> review: \_\_\_\_\_

Rejected by: \_\_\_\_\_ Reason: \_\_\_\_\_ Checked By: \_\_\_\_\_ HIPAA: Yes No

