TOLEDO ELECTRICAL WELFARE FUND
SUPPLEMENTAL FRINGE BENEFIT FUND (SFBF/VEBA)
MAIN CLAIM FORM

419.666.4450 Phone 419.666.5410 Fax veba@electricalfunds.org

Name: _____ SSN / UID #:_____

(Member's Information)

(The **last 4 of your social security number or** your **TEWF 6-digit** Member ID on your **medical insurance card**)

Instructions:

Fill in the necessary information below for health expenses incurred by you or your eligible dependents for which you request reimbursement. Expenses covered under other medical insurance plans must be submitted to those plans first for reimbursement. Then you must attach a copy of the Explanation of Benefits you receive from the other insurance carrier along with this request for reimbursement. Expenses Not Covered under any plans must be accompanied by a paid receipt with a full explanation of the expense**.**
ITEMIZE ALL RECEIPTS YOU ARE SUBMITTING. DO NOT TOTAL ALL RECEIPTS AND PUT ON ONE LINE. LIST EVERY RECEIPT INDIVIDUALLY. Reimbursements are by Direct Deposit ONLY.

TEWF Members: Submit receipts with detail of purchase for vision and prescriptions. Medical and dental out-of-pocket is on file with the Fund Office, no need for receipts unless you have secondary insurance that is not with TEWF. If you have secondary insurance after your primary pays through TEWF, then you must submit your EOB from your secondary insurance. **Eligible health insurance premiums can only be included if the premiums were paid on an after-tax basis (i.e., not through a cafeteria plan).**

Type 1 Benefits examples:	**Type 2 Benefits (Effective on or after January 1, 2005)**
Medical, Dental, Prescriptions, Vision, and mileage.	Dependent Care, Educational Assistance, Long Term Care Insurance and the group Voluntary Term Life Insurance through TEWF

Date of Service	**Name of Patient**	**Your Out-of-Pocket Expense**
		$
		$
		$
		$
		$
		$
	TOTAL	$

☐ **PLEASE READ BEFORE YOU CHECK THIS BOX!! This is an addition to any eligible receipts/out-of-pocket that I have requested above on this form. By checking this box, I am requesting (a one-time only disbursement) of any pended claim amount that would be available to me up to the amount of my contribution balance as of the date of this signed SFBF/VEBA Claim Form. If you are already on the automatic, this box does not apply to you.**

All Contributions after 9/27/04 (October Work Month) are for Type 2 Benefits. I authorize the SFBF to transfer monies from Type 2 to Type 1, if needed, so that I can be reimbursed for Type 1 Benefits.

I hereby request payment from the Supplemental Fringe Benefit Fund for out of pocket health and/or eligible expenses indicated above. I certify that I will not claim these expenses as an income tax deduction and that the expenses comply with the requirement of The Plan. I also certify that I am not receiving reimbursement for the above requested out-of-pocket through any other fund or that the above is eligible to be processed or has been processed through a secondary insurance thus creating or could create a different patient portion. Any eligible amounts paid out to you through the above request cannot be returned back to your SFBF/VEBA Fund.

_____

Member's Signature (Required) **Date**

OTHER INS. _____ FOR OFFICE USE ONLY

AUTO _____ Type 1 _____ Type 2 _____ **Total** $_____

Submit form and receipts by: fax, email (information listed above) or mail to this address:
Toledo Electrical Welfare Fund, P.O. Box 60408, Rossford, Ohio 43460