PLUMBERS AND PIPEFITTERS LOCAL UNION NO. 172
HEALTH & WELFARE FUND

DOLLAR BANK REIMBURSEMENT CLAIM FORM

Name:_____ **Member ID or SS#** _____
PLEASE PRINT

Address: _____ **Telephone Number:**_____
PLEASE PRINT PLEASE INCLUDE AREA CODE

City, State, Zip_____ ☐ Please check here if this is a new address

Enclosed claims are for (check only one) ☐ **Self** ☐ **Spouse** ☐ **Son** ☐ **Daughter**

Dependent's Name _____ **Date of Birth**_____

Is dependent covered by another health insurance plan? ☐ **Yes** ☐ **No**

Instructions for claims submission:
You must enclose a copy of the itemized bill showing the **date of service, patient name and what services were rendered** . The Fund cannot make dollar bank reimbursements on the basis of a bill showing a balance due. Pre-payments for services not yet rendered are not eligible for reimbursements. If you are requesting reimbursement for a medical, dental, vision or hearing expense covered by any group health plan, you must also enclose copies of all of the Explanations of Benefits (EOB's). If the expense was for another reimbursable expense identified in this Plan, you must enclose a receipt for the provider specifically identifying the reimbursable expense, what the expense was for and the date the expense was incurred. **Retain copies of supporting documentation for your records as the submitted documents will not be returned.**

-Missing information may cause a delay in the processing of your claim(s)-

Service Date	Description of Charges	Provider Name	Amount
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			
		Total Expenses:	$ 0.00

Send in a separate form for each family member.

If you do not have sufficient funding in your dollar bank to cover a requested reimbursement, you will be notified by mail.

This is to certify that my statements on this claim form are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable Plan Year and for my eligible dependents. I certify that I have paid these expenses in full and that these expenses have not been, nor will be reimbursed under this or any other benefit plan and will not be claimed as an income tax deduction. I authorize my Dollar Bank Account to be reduced by the amount requested.

_____ _____
Signature of Participant Date

Return Completed Form to:

Plumbers and Pipefitters Local No. 172 Health and Welfare
6525 Centurion Drive
Lansing, MI 48917
(833) 767-0172

DOLLAR BANK REIMBURSEMENT CLAIM PROCEDURES

1) Complete a Dollar Bank Claim Form
2) Send in a separate claim form for each family member
3) Send the completed Dollar Bank Reimbursement Claim form, **together with the appropriate documentation of incurred charges to the Fund Office**
4) Reimbursement checks will only be issued to the participant. Dollar Bank Reimbursements cannot be assigned to a provider.
5) Withdrawals will only be made for claim amounts of $50 or more. You can accumulate and submit several small reimbursable expenses that together total $50, provided all of the expenses were incurred and submitted within filing limit. Reimbursement request may be submitted anytime; however, such requests are limited to once per calendar quarter.

All Claims must be submitted within two (2) years from date of service

ACCEPTABLE DOCUMENTATION:

1) A written statement from an independent third-party such as the provider of service (doctor, dentist, ophthalmologist), itemizing dates of service, service rendered, charges for each service and name and birth date of person receiving services
2) Complete copy of the Explanation of Benefits (EOB) reflecting what charges were submitted to other benefit plans for consideration of available benefits
3) If the expense was for another reimbursable expense identified in the Plan, enclose an itemized statement of the charges. For example, if the expense was for long-term care insurance, enclose a receipt from your insurance agent identifying the nature of the coverage (i.e., long-term care policy), the incurred person, the premium amount and the period of time covered by your premium payment.

EXPENSES THAT DO NOT QUALIFY FOR REIMBURSEMENT:

1) Cosmetic Surgery and treatments;
2) Health Club memberships or expenses;
3) Household help;
4) Maternity clothes;
5) Non-prescription drugs, medicines and vitamins;
6) Expenses that have not yet been incurred, except prepayment of orthodontia expenses;
7) Expenses that are incurred by an individual not covered under the Plan at the time the expense(s) were incurred;
8) Expenses listed in the "reimbursable Expenses" section in the SPD, page 54-55 for which non-taxable reimbursement is later disallowed by the I.R.S.

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