

**SECTION VIII  
REIMBURSEMENT OF MEDICAL EXPENSES**

**A. Reimbursement Policy**

Active, inactive and retired participants may be reimbursed from their hour bank for medical, dental and chiropractic care expenses paid by the participant for the participant and his/her dependents in accordance with the terms and provisions of this section.

**D. Submission of Claims**

When health care expenses are paid by the participant for the participant and dependents, the participant may apply for a reimbursement from his/her Hour Bank for the health care expenses paid as follows:

- a. Participant to obtain Medical Reimbursement Account Reimbursement form and statement of claim form at the Local 13 Fund office.
- b. Participant shall submit the following for consideration for reimbursement:
  - i. A duly completed statement of claim form and Medical Account Reimbursement form including the participants name, address, social security number, signature, patient's name, and the date, amount and description of health care services, and
  - ii. All itemized original bills attached to the claim form, listed per line, and
  - iii. Proof of payment of the health care expenses, (to include copies of cancelled checks or statement of paid services by provider),and
  - iv. When requested, a Certificate of Medical Necessity completed by your physician, dentist, chiropractor in support of your claim, and
  - v. All of the above submitted to the Fund office.
- c. Claims may be submitted at anytime during the year for any reimbursable expenses paid by the participant in the year in which the claim is filed or in any previous year except a claim for expenses paid prior to January 1, 2007 shall not be allowed.

The participant is encouraged to file one claim in any year for reimbursable medical expenses. The cost of processing this first claim is paid for by the Fund. If it is necessary to file more than one claim in a calendar year, the subsequent claims will be at a cost of \$10.00 per claim payable in check form to the Fund office at the time you submit your claim. The minimum amount of any claim submitted should be not less than \$100.00

The participant must have 4 quarters of hour bank premium in reserve before any claims will be processed. The amount available is the amount over the 4 quarters of hour bank in reserve.

**STATEMENT OF CLAIM**

**Hour Bank Reimbursements**

**Mail or bring claim to:  
UA Local 13 Fund Office  
1850 MT. READ BLVD  
Rochester, NY 14615**

**To be completed by Plan Participants: (please print)**

**Member Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City/State/ZIP:** \_\_\_\_\_

**Members SS#:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_

**Patient DOB:** \_\_\_\_\_

**Relationship to member:** \_\_\_\_\_

**I authorize release of any medical information necessary to process this claim.**

\_\_\_\_\_  
**Signed (Member only)**

\_\_\_\_\_  
**Date**

**All expenses submitted for hour bank reimbursement must qualify as tax deductible expenses as defined in IRC Publication 502 (available in the Fund office). All expenses submitted for hour bank reimbursement must have been submitted to the appropriate insurance carrier. No expenses submitted for hour bank reimbursements will duplicate other reimbursements. No expenses submitted for hour bank reimbursement may be claimed as tax deductible on your income tax return.**

**I hereby certify my agreement with the above statements and state that any misstatement or misrepresentation will be my responsibility in regards to income tax penalties.**

\_\_\_\_\_  
**Signed (Member Only)**

\_\_\_\_\_  
**Date**

**Attach all claims for one patient and indicate clearly which items you are claiming, plus a total dollar value for that patient.**

**Claims will be returned for clarification as necessary.**