# VEBA TRUST

# STATEMENT OF CLAIM FOR MEDICAL/DENTAL/VISION EXPENSES OR PREMIUMS

## Instructions for Making Claims for Benefits — Please Follow Steps 1-5 Below

Please list only one person on each claim form. It is O.K. to use photocopies of this form, or you may print claim forms from our website at www.veba.org. Only claims for expenses or premiums incurred subsequent to participant's VEBA membership effective date may be submitted. You may submit a claim at any time.

Step 1. Complete Section A. (To speed processing, please answer each applicable question.)
Step 2. Complete all of Sections B and/or C, and Section D.
Step 3. Attach verification for each part of your claim, such as copies of an itemized billing or the Explanation of Benefits' (EOB) form provided by your insurance company, or a detailed receipt for the over-the-counter medications.
Step 4. Sign and date the back of the form in Section E.
Step 5. Mail or fax completed form and claim verification to the VEBA Plan Administrator.

**VEBA Plan Administrator**
c/o REHN & Associates, Inc.
P.O. Box 5433 • Spokane, WA 99205-0433
1-800-VEBA101 (832-2101)
(509) 534-0600
Fax: (509) 535-7883
E-mail: veba@rehnonline.com
Website: www.veba.org

## SECTION A

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

Your name (plan participant) _____ Soc. Sec. or VEBA Acct. No. _____

Home Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ Work Phone (____) _____ E-mail _____

***Complete if claim is for a spouse/dependent.***

Name of spouse/dependent _____ Date of Birth _____

Relationship to plan participant _____

**Eligible dependents are persons you *could* claim as a dependent on your personal income tax return as defined by Internal Revenue Code Section 152. Qualified dependents are outlined in IRS Publication 501.**

## SECTION B - EXPENSES

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

Please attach verification of your listed claims and follow steps 1-5 above. You may summarize multiple dates of service in a similar category, such as prescriptions, but all the receipts must be attached. If you are a current participant in a Section 125 Health Care Flexible Spending Account (FSA) you must exhaust the FSA benefits before you may file an eligible VEBA claim.

| Date(s) of service | Provider of service(s) | Description of service(s) rendered | Total Out-of-Pocket Expenses |
|---|---|---|---|
| | | | |
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Total Out-of-Pocket Expenses to be reimbursed from your VEBA account $0.00

**If more space is needed, attach an additional sheet of paper. For additional claim forms, please make copies of this form, or print them from our website at www.veba.org, or call 1-800-VEBA101 (832-2101) or (509) 534-0600.**

*Complete All Applicable Sections*

## SECTION C - PREMIUMS

***If your claim includes qualified insurance premiums you must complete this section. 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.***

Please attach verification of payment of premiums.

| Name of Insurance Company | Premium Amount | No. of Months Paid | Total Paid |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

***Note: Premiums paid by an employer or through a pre-tax Section 125 Cafeteria Plan are not eligible for reimbursement.***

Total premiums to be reimbursed from your VEBA account $0.00

## SECTION D - SUMMARY

Total reimbursement for qualified health care expenses (from Section B) $0.00

and/or

Total reimbursement for qualified insurance premiums (from Section C) $0.00

Total to be reimbursed from your VEBA account $0.00

## SECTION E - SIGNATURE

I hereby certify that the foregoing statements are true and correct and that the amount of this submitted claim to the VEBA Plan Administrator 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.

_____

Signature of plan participant

Dated this _____ day of _____ , _____

## SECTION F - OTHER

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

The VEBA Trustees, Sponsors, and the VEBA Plan Administrator hereby disclaim any responsibility for the participant's decisions regarding the taxation of benefits paid from the Trust for medical, dental or vision claims.

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

If you have multiple VEBA investment funds, withdrawals from your account will be withdrawn prorata based on your fund allocation percentage currently on file with the VEBA Plan Administrator, unless you request otherwise.

If you have any questions about your VEBA account, or about a pending claim, or need claim forms, please use the VEBA website or call the VEBA Plan Administrator at 1-800-VEBA101 (832-2101) or (509) 534-0600, or e-mail: veba@rehnonline.com.

Please be sure to notify us in writing or via e-mail of any address change.