OPERATING ENGINEERS LOCAL #49 HEALTH AND WELFARE FUND

Health Dynamics Physical Co-Pay, Deductible, Coinsurance or Gym/Health Club Membership Claim Form

Name: _____ Social Security Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

ID Number: _____ Phone Number: (_____) _____ - _____

E-mail Address: _____

☐ **Co-Pay, Deductible & Coinsurance Eligible Reimbursements**

Please attach the supporting documentation in the order you have it listed below and fill in with dates of service, description, and claim total, then sign and date below and mail or fax to Wilson-McShane Corporation, Attn: Operating Engineers Local #49 Health and Welfare Fund.

(*See back of this form for a description of valid forms of documentation.*)

Other Insurance? ☐ Yes ☐ No ☐ Family ☐ Individual Name of Policy Holder: _____

Name of Insurance Company: _____ Phone Number: (_____) _____ - _____

☐ By requesting this reimbursement, you are certifying that these out-of-pocket expenses have not been nor will be paid by any other insurance. Please check box as certification of this.

☐ **Gym/Health Club Membership Eligible Reimbursements**

Please attach the supporting documentation in the order you have it listed below and fill in with months of service, description, and claim total, then sign and date below and mail or fax to Wilson-McShane Corporation, Attn: Operating Engineers Local #49 Health and Welfare Fund.

(*See back of this form for a description of valid forms of documentation.*)

Date(s)/Month(s) of Service	Description	Dollar Amount
1.		$
2.		$
3.		$
4.		$
5.		$
6.		$
	Claim Total	$

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 any copay, deductible and coinsurance 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.

Signature: _____ Date: _____

Reminders:

- **Sign and date the Reimbursement Form. Wilson-McShane Corporation cannot process an unsigned form.**
- Provide documentation for all expenses submitted. / Keep copies of everything submitted. / Minimum check amount is $25.00.
- Cancelled checks or credit card receipts/statements or Provider statements are not valid forms of documentation without proof of payment.
- **Expenses incurred prior to your initial Health Dynamics Physical or more than 12 months after your last Health Dynamics Physical are not eligible for reimbursement.**
- **Expenses incurred outside of the allowable timely filing limitation of the Plan (24 months) will not be eligible for reimbursement regardless of whether the expense was incurred after your Health Dynamics Physical and within 12 months after your last Health Dynamics Physical.**
- IRS guidelines require that Wilson-McShane Corporation keeps records of all claims and correspondence for three years.

Multiple expenses may be included on one form. If more space is needed, attach additional forms.

Forms of Documentation

Valid Forms of Documentation For Healthcare Services:

- ✓ Explanation of Benefits (EOB) from your insurance.
- ✓ Proof of Co-Pay Payment (Receipt) from your clinic.
- ✓ Proof of Coinsurance amount paid by you to the clinic/hospital.

Exceptions:

- ✓ Itemized list of co-pays or coinsurance receipts from your clinic substantiating payments made to the clinic/hospital.

Valid Forms of Documentation ***must*** include ***all*** of the following:

- Date(s) of Service
- Type of Expense (i.e. co-pay, coinsurance)
- Amount Applied to the Deductible
- Name of the Service Provider
- Participant and/or Patient Name and address

Valid Forms of Documentation For Gym/Health Club Memberships:

- ✓ Proof of Payment (receipt) from your Gym/Health Club.
- ✓ Proof of amount paid by you to your Gym/Health Club.

Valid Forms of Documentation ***must*** include ***all*** of the following:

- Membership Month(s)
- Payment Amount
- Name of the Gym/Health Club
- Member Name and Address

Invalid Forms of Documentation are:

- Credit card statements
- Service provider invoices, bills or statements without supporting EOB or payment detail.
- Gym/Health Club invoices, bills or statements without payment detail

Mail completed forms to:

Operating Engineers Local #49 Health and Welfare Fund
3001 Metro Drive - Suite 500
Bloomington, MN 55425

Phone: (952)854-0795 Fax: (952)851-3521