SASMI HCRA REIMBURSEMENT REQUEST

This Signed Form and Bank Information Must Accompany All Requests

*Reimbursements will only be made electronically thru an ACH directly to your bank. Paper checks will not be issued. Your specific claim information will be available on our website www.sasmi.org

SASMI
Here for you now. There for you later.

SECTION 1: Personal Data (Please Print All Answers)

Name: _____
Last First Middle

Address: _____

_____
City State Zip Code

IA No: _____
Home Local Union No: _____
Social Security No: _____
Date of Birth: _____
Retirement Date: _____
Email Address: _____

Are you currently employed in any capacity YES NO

If requesting reimbursement of Health Insurance Premium(s), please complete the following and attach proof of payment:

☐ Private Insurance Carrier
Name of Carrier: _____
Month(s): _____

☐ SMWIA Local Union _____ Welfare Fund
Name of Local Union Welfare Fund:_____
Month(s): _____

SECTION 2: This section must be completed for all claims incurred by you, your spouse, or other eligible dependents.
You must provide proper supporting documentation so that your claim can be approved. This includes copies of receipts or other documentation, such as an Explanation of Benefits (EOB) from your health plan.

List expenses in the table below and attach a statement or itemized invoice from the individual or entity to which payment for medical expenses were made and for whom they were rendered. **Cancelled checks or undocumented receipts are not acceptable documentation per IRS regulations. Balance due statements will only be accepted if they include the above listed information.** Reimbursable expenses should total at least $200 before being submitted for reimbursement.

Date of Expense	Name of Service Provider	Name of Covered Participant	Service Provided (Doctor, RX, Dental etc.)	Amount Requested for Reimbursement/Payment

TOTAL:_____

SECTION 3: DEATH CLAIM

If this distribution is for expenses of a deceased Participant, you must provide a copy of the death certificate.

SECTION 4: SIGNED CERTIFICATION AND INFORMATION - REQUIRED TO PROCESS CLAIMS

I request payment from the reimbursement account for the expenses listed above from the National Stabilization Agreement of the Sheet Metal Industry Trust Fund and its Retiree Plan of benefits ("SASMI"). I state that the good or services for which I am requesting reimbursement have been paid and have not been reimbursed by any other Insurance company, Local Union Health Fund or any other entity. I understand that a false statement or the withholding of pertinent information may disqualify me from benefits. I understand that I am responsible for providing SASMI with the required proof of payment(s) and/or receipt(s) and that SASMI will not issue HCRA Benefits for claims not received within two (2) calendar years after goods or services were received. If any of the above information changes, I agree to notify the SASMI office in writing within fifteen (15) days. I hereby authorize SASMI to obtain protected health information (including medical and billing records) and Social Security, unemployment, Health and Welfare, Health Insurance, and other records for the sole purpose of processing my claim for SASMI benefits. I understand that this authorization is voluntary, and that SASMI may not pay a claim without verification.
I state under penalty of perjury that the foregoing is true and correct.

Signed on [Date]: _____ Applicant's Signature: _____

Voided Check ONLY required if your banking info is new or has changed

Name of Bank: _____

Bank ABA Number: _____ **Account Number:** _____
Proof of account ownership required: For Checking Account Attach **VOIDED CHECK.** For Savings Account Attach **BANK DOCUMANTATION-DEPOSIT SLIP**

FAX
703-549-9613

SASMI Trust Fund
3180 Fairview Park Dr., Ste. 150
Falls Church, VA 22042

Phone
703-739-7250

HOW TO FILE YOUR CLAIM FORM

SECTION 1: Complete ***ALL*** personal information on the reverse side of this form.

SECTION 2: Indicate the amount of each healthcare claim being submitted. This account reimburses you for services **incurred** for healthcare purposes. The type of service rendered determines claim eligibility. Not all healthcare expenses are reimbursable. *(See IRS Section 213(d) for guidelines).*

HEALTH CARE EXPENSES – must be incurred by you, your spouse, or other eligible dependents prior to reimbursement. Attach to this claim form one of the following:

- The Explanation of Benefits (EOB) statement returned to you from the insurance carrier indicating the amount for which you are responsible. Please be advised that any medical, dental, or vision expense covered by insurance in part or in full must first be submitted to your insurance carrier.
- Co-pay receipts if you are covered under a managed care or prescription drug plan
- When there is no insurance for healthcare expenses, submit an itemized bill with the following information:
    - Name of provider and patient
    - Service cost, date, and description
    - Notation when there is no insurance coverage

Total your expenses and enter the amount on the front of this form. **Cancelled checks or undocumented receipts are not acceptable documentation per IRS regulations. Balance due statements will only be accepted if they include the original date of service, description of services provided, and the cost of the services rendered.**

Insurance premiums must also be incurred prior to reimbursement (i.e., March premium can be reimbursed earlier than February).

SECTION 3: If this distribution is on behalf of a deceased Participant, you must provide a copy of the death certificate. Once we have received a copy of the death certificate, SASMI will keep it on file for future reference for future claims. Therefore, SASMI only requires that a copy of the death certificate be sent once.

SECTION 4: **SIGN the claim form.** This is required on all submissions; otherwise the claim will not be processed. This Health Care Reimbursement Account is regulated by the Internal Revenue Service. Our documentation guidelines are provided to help you determine what qualifies as a reimbursable expense and to assist us in the adjudication process. It is the responsibility of each participant to comply with these guidelines and to avoid submitting duplicate or ineligible claims. Failure to comply with the above guidelines will delay the payment of your claim.

This outline is intended for quick reference. For more specific guidelines, please call SASMI **1-800-858-0354** for detailed questions.

A HCRA Allowance may be used to reimburse eligible health care expenses incurred by the Participant, Spouse or eligible Dependents which are not covered or reimbursed in full by a health plan or insurance policy. Reimbursable expenses are those that constitute "medical care" under Section 213 of the Internal Revenue Code. A HCRA Allowance may be used to reimburse the Participant for Plan deductibles, co-payments, and other non-covered expenses for medical, prescription drug, dental, vision, and psychiatric services. A HCRA Allowance may also be used to pay for self-pay premiums, COBRA premiums, other medical plan coverage, Medicare supplemental coverage, Medicare Part B or D monthly payments, and long-term care insurance premiums (but not life insurance premiums). Generally, no benefit will be paid from a Participant's HCRA Allowance if the cumulative amount is less than $200.00.

To be eligible for reimbursement:

- the expenses must be incurred on or after January 1, 2014; and
- the expenses must be submitted within 24 months after the date the claim was incurred. Claims submitted after 24 months will be denied. Claims will be reimbursed under the provisions of the SASMI Retiree Plan up to the total balance of your account.
- Supporting documentation must be provided together with this form, describing the expenses and proving that the Participant (or eligible Spouse or other eligible Dependent) paid the expenses. Supporting documentation may include, but is not limited to:
    a) An itemized bill describing the services provided, the person to whom the services were provided, the name of the provider, the date of service, and the charged amount;
    b) An Explanation of Benefits (EOB); or
    c) An original receipt showing proof of payment.
- **You must supply banking information for reimbursements to be processed, but only if banking information is new or has changed**

If you lost a receipt, contact your doctor or pharmacy to request a copy, or call your health plan for an Explanation of Benefits (EOB) form. If you don't provide the necessary information, the processing of your claim may be delayed.