SOUTHERN CALIFORNIA IBEW-NECA
RETIREE HEALTH PLAN
PREMIUM REIMBURSEMENT POLICY INFORMATION FORM

PARTICIPANT INFORMATION

Name: _____
(Last) (First) (Middle)

Address: _____
(Street) (City) (State) (Zip)

Phone: (_____) _____ Social Security Number: _____

FAMILY INFORMATION – Please list spouse's information if enrolled					
	Last Name	First Name	M.I.	Social Security Number	Date of Birth
YOU					
SPOUSE					

CLAIM REQUIREMENTS

Timely filing limit is 15 months. Please submit claim with the following documentation for prompt processing.

Submit this completed form with each request. (i.e. If you are requesting reimbursement for January, February, and March, only one form is required if one payment was made and all months are submitted at the same time.)

Submit one or more of the following as proof of premium payment:
(Check all documentation attached)

☐ Cancelled Check ☐ Bank Statement (online statement acceptable) ☐ Other

☐ Credit Card Statement ☐ Payroll Stub with automatic deduction

Premium Amount: $ _____ Check one: ☐ Monthly ☐ Quarterly ☐ Yearly

Premium payment dates requested for reimbursement. * (Circle all that apply)

January	February	March	April	May	June
July	August	September	October	November	December

* Future payments will not be reimbursed until the end of the month requested. (i.e. June payments will be reimbursed the first part of July.)

Upon completion of this form, return it with the required documentation to:

IBEW-NECA Claims Administration
2831 Camino Del Rio South, Suite 311
San Diego, CA 92108-3829
Telephone: (800) 736-0401

X _____ _____
Participant Signature Date Signed