SOUTHERN CALIFORNIA IBEW-NECA
RETIREE HEALTH PLAN
PREMIUM REIMBURSEMENT CLAIM FORM

www.scibew-neca.org **www.scibew-neca.org**

PARTICIPANT INFORMATION

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

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

Phone: (_____)_____ Last four digits of SSN: XXX-XX-_____

The Premium Reimbursement provides an option to obtain private insurance on your own and receive a limited dollar amount reimbursement from the Retiree Health Plan for your private medical insurance. Please refer to the Retiree Health Plan Summary Plan Description for details on the Premium Reimbursement Plan and its benefits.

CLAIMAINT INFORMATION					
	Last Name	First Name	M.I.	Social Security Number	Date of Birth
YOU					
SPOUSE					

INFORMATION REGARDING CLAIM SUBMISSION

Complete this form and submit with each reimbursement claim. Only one claim form is required regardless of the number of months for which reimbursement is claimed. Claims for reimbursement will not be made in advance of coverage. **Claims are processed after eligibility is verified, and in the order in which they are received.**

Beginning April 1, 2014, the Premium Reimbursement Plan was replaced by an insured program provided by UnitedHealthcare. Until September 30, 2015 Allied Administrators, Inc. will continue to process Premium Reimbursement Claims for premium expenses incurred to provide coverage through March 31, 2014. No further benefits will be payable under this Plan for expenses incurred on or after April 1, 2014.

A completed "Premium Reimbursement Claim Form" must be submitted with all claims. 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 deduction indicated

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

If you have any questions, please contact the number shown below. Upon completion of this form, return it with the required documentation to the following address. Be sure to retain a copy for your records:

Allied Administrators
An ATPA Company
PO Box 24160, Oakland, CA 94623-2416

X_____ _____
Participant Signature **Date Signed**