

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

Web: www.scibew-neca.org

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PARTICIPANT INFORMATION

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

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

Phone: (____) _____ Last four digits of SSN: _____

The Premium Reimbursement Plan provides an option to obtain private insurance on your own and receive a limited dollar 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.

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

INFORMATION REGARDING CLAIM SUBMISSION

The last day to request reimbursement of your individual medical premium from the Plan is within fifteen (15) months from the month for which you paid for coverage. A completed "Premium Reimbursement Claim Form" must be submitted with all claims.

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.

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.

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

Participant Signature	Date Signed	Spouse's Signature	Date Signed
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This form is also available online at www.scibew-neca.org