

VEBA CLAIM FORM

Reimbursement of Payment Request

Employer Name

Employee Information

Name (Last, First, Middle Initial)

Social Security Number (Last Four Numbers are Required)

Address (Street)

Address (City, State, Zip) Check Here If New Address

Employee Email Address

Names of Dependents

(For whom expenses are currently being submitted.)

Dependent Name	DOB	Relationship
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I hereby certify that the information on this claim form is correct and authorize release of payment through my reimbursement account. I understand that reimbursement is not a guarantee that this payment is tax exempt. I have not received and will not receive reimbursement for these expenses from this or any other plan.

Employee Signature _____ Date _____

Please Note: There is a \$100 minimum expense before reimbursement will be made. Requests will be held until the minimum has been met.

Where To Send a Claim:



Mail: Nyhart
Claim Reimbursement
8415 Allison Pointe Boulevard, Suite 300
Indianapolis, IN 46250-4159

Email: support@nyhart.com

Fax: 1-888-887-9961

Phone: 1-800-284-8412

317-845-FLEX (3539)

Expenses to be Reimbursed

Health Care

Expenses must be ineligible or non-reimbursed by medical/dental plan, the service must be provided while participating in the plan.

Type of Expense	Date Incurred	Amount
Medical		
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
	Total	\$ _____
Dental		
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
	Total	\$ _____
Vision		
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
	Total	\$ _____
Health Premiums		
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
	Total	\$ _____
Other		
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
	Total	\$ _____

Instructions for Filing a Claim

For medical/dental/vision expense claims that were submitted to a health plan or an insurance company but were not fully paid by that carrier, attach copies of other insurance carrier claim and/or payment forms (explanation of benefits forms) to establish amounts not covered under the medical/dental/vision plan.

For all other reimbursable expenses, copies of all bills must be attached that show who (name and address) rendered the service, reason for charge, and date and amount of charge. Cancelled checks are only acceptable for premium reimbursements.

Employee must complete, sign, and date this claim form. Keep a copy for your records.