

# Flexible Benefits Plan Claim Form

OFFICE USE ONLY: Claim Number: \_\_\_\_\_



## Employee Information http://harrisonflex.aibpa.com

Last Name (Print)	First Name	MI	Phone Number	<b>Submit Claims To:</b>  Harrison Flex Plan 1220 SW Morrison Street Suite 300 Portland, OR 97205 Fax (503) 228-0149
Street Address	City	State	Zip	
<input type="checkbox"/> Check if new address	Social Security Number		Date of Birth	

## Patient Information

**INSTRUCTIONS:** Please provide claim patient information. Is the patient:  Self  Spouse  Child  Other. If other, specify: \_\_\_\_\_  
**NOTE: No patient information required when submitting Explanation of Benefits from insurance company.**

Last Name	First Name	MI	Social Security Number	Sex	Date of Birth (mo/day/year)	Disabled	Full Time Student
				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

## Type of Claim

**INSTRUCTIONS:** Please mark the box for the benefit for which you are submitting a claim. Be sure to refer to your Benefits Booklet for eligibility requirements and for information on how to apply for each specific benefit.

<input type="checkbox"/> Supplemental Workers' Compensation	<input type="checkbox"/> Supplemental Unemployment	<input type="checkbox"/> Benefit Dislocation <input type="checkbox"/> First half of account <input type="checkbox"/> Second half of account	<input type="checkbox"/> Medical Care Reimbursement Plan	<input type="checkbox"/> Premium Pay Plan For Harrison Health Plan Coverage ONLY	<input type="checkbox"/> Dependent Care Reimbursement Plan <input type="checkbox"/> Filing Jointly <input type="checkbox"/> Filing Single
You must provide proof of Workers' Compensation payment.  Number of weeks requested _____  <b>Taxable</b>	You must provide proof of unemployment payment. Date(s) and Number of weeks requested _____  <b>Taxable</b>  Local _____	Local 48 will verify eligibility.  You are relocating to Local _____ @ Phone number _____  Address _____  <b>Taxable</b>	You must submit an Explanation of Benefits showing date and type of service or Medical Care Expense Receipts.  Amount requested: \$ _____  Dates From _____ Thru _____	Amount requested: \$ _____  Partial Payment/Full Payment for Continued Health Coverage  *No check generated	Please submit Dependent Care Expense receipts showing dates of service and name, address, and TAX ID number of person(s) performing the service.  Amount requested: \$ _____

## Signature of Participant

**For Dependent Care Reimbursement: I certify that I have no other separate dependent care program through any employer. Please initial here: \_\_\_\_\_.**  
**For Wage Replacement Claims: Please submit a W-4 form along with your claim. If you do not submit a W-4 form, taxes will be taken out based on taxes for a married person, filing jointly. Forms are available at <http://harrisonflex.aibpa.com> or <http://www.irs.gov>.**

I certify that I have read the instructions and that the above information is complete and accurate. I also certify that all claims submitted will be only for myself or for my dependents that are eligible for benefits under the plan. Additionally, I certify that there is no other coverage for my dependents or me provided by another insurance company or employer for the benefit that I am seeking coverage. I understand that I will be responsible to reimburse the Trust Fund for all amounts paid in connection with claims for me or my dependents if I make any false statements or misrepresentation in this form or in any claim form or if I conceal any information pertaining to any such claims. I agree to provide the Trust Fund, upon request, with verification of any information. I give permission to A&I Benefit Plan Administrators to examine records pertaining to myself or covered dependents as required to process claims.

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date