Unified Fire Authority VEBA Trust

Mailing Address: PO Box 26237 - Salt Lake City, Utah 84126-6237
Hand Delivery Only: 1293 W 2200 S, Suite A - Salt Lake City, Utah 84119
Phone 801-973-1001 Fax 801-975-1342
ufaveba@compusysut.com

VEBA ACCOUNT REIMBURSEMENT REQUEST FORM

1. Type or print information (items 1 through 5) on the Employee Section below.
2. Enter the items for which the claim is being made in Section 6. A minimum of $25 should be accumulated before you submit a claim.
3. **Supporting documentation must accompany this request form. Supporting documentation includes the following:**

   Explanation of Benefit Statement(s) indicating deductibles, co-insurance, co-payment or amounts in excess of usual and customary charges from any medical/dental plan(s) under which you and/or any of your eligible dependents are covered. If the expense is not covered under your medical/ dental plan, you may provide itemized bills from doctors, dentists or other suppliers for medical expenses. For self-payments, provide a billing statement for coverage from your insurance carrier. ***Credit card receipts, cancelled checks, bank statements or balance forward statements cannot be accepted.***
4. **Retain copies of supporting documentation for your records as these will not be returned to you.**
5. Mail, fax, or email the completed claim form and supporting documentation to the Administrative Office at the address above or numbers listed above. If sending by mail, please use a secure personal and confidential envelope.

NOTE: ANY ITEMS FOR WHICH YOU ARE REIMBURSED CANNOT BE CLAIMED AS DEDUCTIONS OR CREDITS ON YOUR FEDERAL INCOME TAX RETURNS.

1. Employee's Name	2. SSN (last four digits required)	3. Mailing Address
4. Telephone Number	5. Email Address	
I also certify that I have the following insurance coverage(s): ☐ Medical ☐ Dental ☐ Vision ☐ Pharmacy		

6. HEALTH CARE EXPENSES TO BE REIMBURSED

Date of Service	Name of Patient	Description of item to be reimbursed (co-payment, deductible, insurance self-payment, etc)	Amount Requested
		Total Amount Requested for Reimbursement:	

I certify that either I and/or my eligible dependents have Incurred the expenses for which reimbursement is claimed from the VEBA Trust Account, and I further declare that I have not and will not deduct these expenses on my individual income tax returns. No assignment will be accepted:

Employee Signature Date