UFCW LOCAL 1776 AND PARTICIPATING EMPLOYERS
HEALTH AND WELFARE FUND

Flexible Benefits Plan Claim Form Instructions

VERSION: 1/8/26

This claim form must be completed if you are requesting out-of-pocket medical expense reimbursement (1) under the Dual Income Option, (2) from your Flexible Spending Account, or (3) if you are requesting payment from your Paid Time-Off Bank.

Section A: General Information

All participants must complete this section of the claim form in order for the claim to be processed.

Section B: Release of Information Authorization

All participants must read, sign and date the Authorization Statement in order for the claim to be processed.

Section C: Reimbursement Request

All participants must complete this section of the claim form. Check the applicable box(es) to indicate the program from which you are requesting reimbursement, and complete the corresponding section below.

Section D: Dual Income Option - Summary of Medical Expenses Incurred

If you are requesting reimbursement under the Dual Income Option, complete the chart in this section of the claim form. If additional room is needed, you must attach and submit a list of your expenses in the same chart format.

This claim will NOT be processed without an itemized bill, an Explanation of Benefits ("EOB"), and proof of payment submitted for each expense listed. Please refer to the table below for more detailed information.

Itemized bills must include:	You may be able to obtain an EOB from:	Proof of payment may include:
• Name and address of provider • Date of service • Amount billed for each service • Patient's full name • Type of service provided • Amount paid by the patient	• Your insurance provider • Your health care provider	• Cancelled check • Cash receipt* • Credit card statement* *Documentation must include sufficient detail to support the claim

Section E: Flexible Spending Account - Summary of Medical Expenses Incurred

If you are requesting reimbursement from your Flexible Spending Account, complete the chart in this section of the claim form and provide an itemized receipt. If additional room is needed, you must attach and submit a list of your expenses in the same chart format.

This claim will NOT be processed without an itemized receipt and such other documentation as may be required by the Fund.

Section F: Paid Time-Off Bank

If you are requesting payment of Paid Time-Off Benefits, complete this section of the claim form. Please note that you may request payment of Paid Time-Off Benefits no more frequently than quarterly.

ADDRESS: 3031B Walton Road | Plymouth Meeting, PA 19462 | **EMAIL:** fund@1776funds.org | **FAX:** (610) 941-9602

UFCW LOCAL 1776 AND PARTICIPATING EMPLOYERS
HEALTH AND WELFARE FUND

Flexible Benefits Plan Claim Form

Please read all instructions before completing.

A. General Information (Required)

Full Name (Last, First M.I.):		Last 4 Digits of SSN:	
Address:	City:	State:	Zip:
Employer Name:	Store Number:	Date of Hire:	

B. Release of Information Authorization Statement (Required)

I hereby authorize any health care provider or insurance carrier to disclose/release information necessary to process this Benefits Claim Form.

Participant Signature:	Date:
Phone Number (Home):	Phone Number (Cell):

C. Reimbursement Request

Check all that apply:

- ☐ **Dual Income Option** (complete section "D" below)
- ☐ **Flexible Spending Account** (complete section "E" below)
- ☐ **Paid Time-Off Bank** (complete section "F" below)

D. Dual Income Option – List of Medical Expenses Incurred

Participants who have incurred eligible medical expenses and are requesting reimbursement under the Dual Income Option must complete this section. If additional room is needed, you must attach and submit a list of the additional expenses in chart format, as shown below.

Patient's Name	Patient's Date of Birth	Date of Service	Type of Service	EOB Enclosed? (Yes/No)	Itemized Bill Enclosed? (Yes/No)	Reimbursement Request Amount
						$
						$
						$

Certification

I hereby certify that the expenses listed above have not been reimbursed to me, my spouse, or dependents, under any other group health or insurance plan, program, or arrangement that covers me, my spouse, or my dependents by any other third party.

Participant Signature:	Date:

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E. Flexible Spending Account – List of Medical Expenses Incurred

Participants who have incurred eligible medical expenses and are requesting reimbursement from the Flexible Spending Account must complete this section. If additional room is needed, you must attach and submit a list of the additional expenses in chart format, as shown below.

Patient's Name	Patient's Date of Birth	Date of Service	Type of Service	EOB Enclosed? (Yes/No)	Itemized Bill Enclosed? (Yes/No)	Reimbursement Request Amount
						$
						$
						$

Certification

I hereby certify that the expenses listed above have not been reimbursed to me, my spouse, or dependents, under any other group health or insurance plan, program, or arrangement that covers me, my spouse, or my dependents by any other third party.

Participant Signature:	Date:

F. Paid Time-Off Benefit

Participants requesting Paid Time-Off Benefits must complete this section.

I am requesting benefits for the following month(s):

☐ January ☐ February ☐ March ☐ April ☐ May ☐ June
☐ July ☐ August ☐ September ☐ October ☐ November ☐ December

Acknowledgement

I hereby acknowledge that the credits received under this option are considered taxable income. By filling out the Paid Time Off section of this form, I certify that payment of PTO is for time that I could have worked but did not. Furthermore, I elect to have my PTO paid via direct deposit or RAPID Pay Card.

Participant Signature:	Date:

Mailing Completed Form

Once complete, mail this form and all required documentation to the Fund Office at:

UFCW Local 1776 and Participating Employers Health and Welfare Fund
3031 B Walton Road
Plymouth Meeting, PA 19462
ATTN: Flexible Benefits Plan

If you have any questions about your Flexible Benefits, this claim form, or need assistance in completing this form, contact the Fund Office at 610-941-9400 or toll free at 1-800-458-8618, or visit www.ufcw1776benefitfunds.org.