# WISCONSIN ELECTRICAL EMPLOYEES
# HEALTH AND WELFARE PLAN
# FLEXIBLE BENEFIT ACCOUNT PROGRAM

## EMPLOYER VERIFICATION FORM
## FOR HEALTH INSURANCE PREMIUM EXPENSES

*Name of Employee_____

*Name of Employer and Address_____

_____

The above named Employee is enrolled for coverage under the following plans:

| | Date Coverage Began | Date Coverage Ended | Premium Amount |
|---|---|---|---|
| Health Plan | | | |
| Dental Plan | | | |
| Vision Plan | | | |
| Prescription Drug Plan | | | |
| Other (List other health care coverages) _____ | | | |

Check one:

☐ **The Employer does not allow employees to pay for their portion of health insurance premiums on a pre-tax basis through a section 125 cafeteria plan.**

☐ **The Employer maintains a section 125 cafeteria plan under which employees may pay for health insurance premiums on pre-tax basis.**

_____ _____

Contact Person and Telephone Number For Above Named Employer — Telephone Number

_____ _____

Signature of Contact Person — Date

By signing below, I give the Wisconsin Electrical Employees Health and Welfare Plan permission to contact the Employer named above for additional information, if required, about my health plan coverage dates and premium payments.

_____ _____

Employee Signature — Date

Employee's Relationship to Participant Enrolled in Wisconsin Electrical Employees Health and Welfare Plan: _____

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## FORM FOR EMPLOYEES SEEKING REIMBURSEMENT OF HEALTH INSURANCE PREMIUMS

| | Item 1 | Item 2 |
|---|---|---|
| **Coverage Period of Health Plan for Requested Reimbursement** | | |
| **Name of Persons Covered Under Health Plan and Relationship to You** | __ Self<br>__ Spouse<br>__ Dependent | __ Self<br>__ Spouse<br>__ Dependent |
| **Total Amount Of Expense** | | |
| **Amount Reimbursed Previously or Payable Under Another Plan** | | |
| **Amount of Reimbursement Requested** | | |

Documentation Required: You must submit an invoice or other statement from the insurance carrier or your spouse's Employer which states the premium amount, verifies that coverage was in effect during the period for which reimbursement is requested and verifies that no portion of the premium could have been paid pre-tax under a section 125 cafeteria plan. Attach Employer Verification Form for Health Insurance Premium Expenses if you are requesting a reimbursement for your spouse's health insurance premiums.

Certification: To the best of my knowledge and belief, my statements in this Form are complete and true. I certify all of the following:

- If the Premium Expense is for my Spouse or Dependent, the person listed is my spouse or dependent as defined under Internal Revenue Code section 152 without regard to subsections (b)(1), (b)(2) and (d)(1)(B).
- I have not been reimbursed previously for these Premium Expenses under the Flexible Benefits Account Program.
- The Premium Expenses have not been reimbursed and are not reimbursable under any other health plan, such as under a plan of my spouse's employer.
- No portion of the Premium Expenses could have been paid pre-tax under another employer's Code section 125 cafeteria plan. (See attached Employer Verification Form for Premium Expenses.)
- I understand that the Premium Expenses reimbursed may not be used to claim any federal income tax deduction or credit.

I authorize a deduction in my Flexible Benefit Account in the amount of the reimbursement.

_____ _____

Participant Signature Date