VEBA Claim Form
Reimbursement of Payment Request

Employer Name

Employee Information

Name (Last, First, Middle Initial)

Social Security Number

Address (Street)

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

Names of Dependents:
(For whom expenses are currently being submitted.)

Dependent Name	DOB	Relationship

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's Signature

Employee's E-Mail Address

Date:

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

Submit Claim to: VEBA Claim Reimbursement
Nyhart
8415 Allison Pointe Boulevard, Suite 300
Indianapolis, Indiana 46250-4205

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	$

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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.

Mail to:

Attn: VEBA Claim Reimbursement
Nyhart
8415 Allison Pointe Boulevard, Suite 300
Indianapolis, Indiana 46250-4205

For any questions regarding a claim, call:

Nyhart
Indianapolis: 317-845-FLEX (3539)
Toll-Free: 800-284-8412
Fax: 888-887-9961

or Send E-mail to: flexplans@nyhart.com