Theatrical Stage Employees Health & Welfare Trust

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Administered by
Welfare & Pension Administration Service, Inc.

HEALTH REIMBURSEMENT ARRANGEMENT CLAIM FORM

I hereby request reimbursement for qualified out-of-pocket expenses as defined in the Summary Plan Description. Proof of out-of-pocket expenses is attached.

PLEASE PRINT

EMPLOYEE INFORMATION			
EMPLOYEE NAME – First Initial Last	☐ M ☐ F	**WPAS ID # OR SOCIAL SECURITY #**	**EMPLOYEE BIRTHDATE** Mo. Day Year
HOME ADDRESS STREET	**CITY**	**STATE ZIP**	**PHONE #**
***PATIENT'S NAME – First Initial Last**	☐ M ☐ F	**PATIENT BIRTHDATE** Mo. Day Year	**RELATION TO EMPLOYEE** ☐ Self ☐ Spouse ☐ Child ☐ D.P.

**One claim form per patient.*

PLEASE SIGN AND DATE HERE: I certify that all information provided is correct and that the proof of out-of-pocket expense(s) submitted are for me or members of my family who are eligible dependents. The patient has incurred out-of-pocket expenses that have not been paid by any other group health plan or insurance policy. I authorize release of all information contained on this claim to Welfare & Pension Administration Service, Inc., the Plan Administrator. Any person who knowingly and with intent to defraud the Plan or other person files an application for benefits or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Patient Signature: _____ Date: _____
(or Member Signature if Patient is Minor)

The Plan provides reimbursement for out-of-pocket expenses incurred by you and any eligible dependent you claim as a dependent on your Enrollment Form.

If claim is for a dependent, please sign below confirming that the dependent is listed as an eligible dependent on your Enrollment Form.

Member Signature: _____ Date: _____