Electrical Workers Health & Welfare Fund

Please attach documentation to the back of this form
Please make copies of this form for future use

Post-Retirement Personal Care Account (PCA)

Name:_____ SS No.: _____

Address: _____

City: _____ State: _____ Zip Code: _____

ID No.:_____ Phone No.: (_____) _____

E-mail Address: _____

Pleases select the type(s) of refund you are utilizing, and then fill in all areas of that section.

❑ 1. Self Payment / Retiree Payment Reimbursements *Please fill month(s) of refund and dollar amount(s).*

1.	$
2.	$
3.	$

Total: $

Valid Form(s) of Documentation for medical insurance premiums:

Paycheck stub.

Document(s) must include:

- ✓ Name of employee
- ✓ Medical insurance premium amount paid and date.

Statement of payment(s) made or Receipt(s) from Employer or Insurance carrier.

Document(s) must include:

- ✓ Name of company providing the statement or receipt
- ✓ Name of the insured
- ✓ Monthly medical insurance premium amount
- ✓ Amount(s) paid and date(s) of payment.

Invalid Forms of Documentation are:

Credit card receipts

Cancelled checks

Reminders: Sign and date the Reimbursement Form. Wilson-McShane Corporation cannot process an unsigned form.

This is to certify that my statements on this Claim Form are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for my eligible dependents. I certify that these expenses have not been, nor will be reimbursed under this or any other benefit plan and will not be claimed as an income tax deduction. I authorize by PCA account to be reduced by the amount requested.

Signature:_____ Date: _____

Mail Completed Forms to:

Wilson-McShane Corporation
Attn: Electrical Workers Health & Welfare Fund
2002 London Road - Suite 300
Duluth, MN 55812
Phone: (218) 728-4231
Fax: (218) 728-4773