Mail To: **WATKINS EMPLOYEE BENEFITS**

P.O. Box 1738 • Atlanta, GA 30301-1738 • 404-873-2939

All Lines Must Be Completed For Claim To Be Accepted

Group Health Claim Form - Employee's Statement

Claim Form Expense Type (Circle as many as apply) MEDICAL DENTAL PRESCRIPTION FLEXIBLE SPENDING ACCOUNT ALL

Employee Name	Social Security Number Date of Birth	Sex M F ☐ ☐	☐ Single ☐ Divorced ☐ Married ☐ Widowed (Excluding Common Law Marriages) ☐ Legally Separated

Spouse's Name DOB	Spouse's Soc. Sec. #	Is Your Spouse Employed? ☐ Yes ☐ No	If Yes, Give Name, Address & Phone Number of Employer

Does your spouse have group health coverage? ☐ Yes ☐ No	Spouse Insurance Company Name, Address & Phone Number	Group #

Patient Name	Patient's Relationship to employee ☐ Self ☐ Spouse ☐ Child ☐ Step Child ☐ Other

Does the patient have group health coverage? ☐ Yes ☐ No	Insurance Company Name, Address & Phone Number	Group #

Patient's Address if different than employee's	Patient's Date of Birth	Patient's Sex ☐ Male ☐ Female

Is Patient Married? ☐ Yes ☐ No Is Patient Employed? ☐ Yes ☐ No	Is Patient a Full Time College Student? ☐ Yes ☐ No	If Patient is a Full Time College Student, please give school name, address & phone number

About when did symptoms first appear? Work related? ☐ Yes ☐ No	Nature of accident or illness (If an accident, please tell - how - when - where)

Is this bill covered by: ☐ Auto ☐ Group ☐ Work Comp. ☐ Medicare ☐ School ☐ Individual ☐ Other	Policy Number	If this bill is covered by other insurance, tell us who we should contact including their name, phone number and address

READ CAREFULLY BEFORE SIGNING

In signing this form I certify and agree:

1. That the information I have provided is true to the best of my knowledge.
2. That my employment may be terminated and I may be charged with criminal conduct if I knowingly submit a false claim form.
3. That Watkins Associated Industries, Inc. Group Health Administration (the "Plan Administrator") may conduct an investigation of this claim and the information contained in this Claim Form.
4. That my physician(s) and any other provider(s) of medical services, including any other insurer or provider of indemnity protection to me, are authorized to release to the Plan Administrator, any information requested by the Plan Administrator necessary to determine benefits payable under the Plan.
5. That the Plan Administrator is authorized to release any information on this Claim Form and any other information the Plan Administrator obtains regarding this claim to anyone it deems necessary to determine benefits under the Plan.
6. That a photostatic copy of this authorization shall be as valid and enforceable as the original.
7. I hereby certify that the above information is correct and authorize payment through my Flexible Spending Account. I understand that reimbursement is not a guarantee that this payment is tax-exempt. I have not received reimbursement for these expenses previously from the reimbursement account or any other plan.

Employee's Signature _____ Date _____

Spouse's Signature _____ Date _____

Mailing Address _____
STREET CITY STATE ZIP

Home Phone Number _____

IMPORTANT

1. Be sure ALL questions are answered.
2. Attach original itemized bills from Hospital, Physician, Surgeon, etc., if claim is filed for these benefits.
3. Send to Watkins at the above address
4. Make sure you have signed & completed the **EMPLOYEE'S STATEMENT** in full before submitting the form.
5. All charges must be submitted within 180 days of the date of service.

PROCEDURE FOR FILING A FLEXIBLE SPENDING ACCOUNT CLAIM

In order for your claim to be processed in an accurate and timely manner, please be sure that **all** of the information requested on the form is complete and accurate. A separate claim form is required for each expense incurred under our plan. If a bill is being submitted directly to Watkins Employee Benefits, please prepare a claim form and give it to your health care provider so it can be submitted with the bill.

Additionally, you must use this form to file for reimbursement under our Health Care Reimbursement (HCR) Plan, if you are participating. All medical, dental and other related expenses will first be considered by our Group Health Plan and then reimbursed by our Health Care Reimbursement Plan. Therefore, it is important that the claim form be prepared in the same correct manner as if you are filing a group health claim. This form can be used for multiple bills **if each bill** is properly identified in the Nature of Illness space. For example:

1.	New eyeglasses	$300.00
2.	Dental / Orthodontics	1,500.00
3.	Office Copay	15.00

It is important that a separate claim form be used for each person. **Do not combine multiple dependents on one claim form.** If you are submitting a claim through the HCR Plan, please attach the original bills to the form.

Do not submit Dependent Care Reimbursement (DCR) requests on this form.

ACCEPTABLE REIMBURSABLE ITEMS THROUGH THE HCR PLAN

- Amounts not paid by your medical care plan, such as the deductible or the percentage coinsurance you pay. If you or a dependent are covered under two health care plans, only the amount not paid by either plan is eligible for reimbursement.
- Deductibles and coinsurance for other health, dental or vision plans under which you or your dependents are covered.
- Expenses not covered by your medical care plan.
- Virtually all dental expenses (including orthodontics), to the extent not reimbursed under your dental plan.
- Virtually all vision expenses. This includes eyeglasses, contact lenses, and the cost of products to maintain contact lenses such as saline solution.
- Hearing expenses, including hearing aids, special instructions or training for the deaf (such as lip reading).
- Individual psychiatric or psychological counseling (including drug and alcohol rehabilitation), to the extent not reimbursed under your medical plan.
- Transportation expenses to receive medical care, including fares for public transportation and actual out-of-pocket care expenses such as gas and oil. In lieu of out-of-pocket expenses.
- Miscellaneous expenses, including birth control pills, and a stop-smoking program if prescribed by a physician.

ITEMS NOT REIMBURSABLE BY IRS REGULATIONS

1. Cosmetic surgery
2. Amounts reimbursable by spouses' or other group health plans.