



SACRAMENTO AREA ELECTRICAL WORKERS TRUST FUNDS

| Employee Information    |   |                                    |                                     |
|-------------------------|---|------------------------------------|-------------------------------------|
| Employee Name           | Social Security Number                                  | Patient's Name                     | Relationship to Covered Employee    |
| Employee Home Address   |   | City                               | State Zip                           |
| Reimbursement for Plan: | <input type="checkbox"/> Western Health Advantage (WHA) | <input type="checkbox"/> Aetna PPO | <input type="checkbox"/> Kaiser HMO |

| Type of Service | Provider's Name | Date of Service (MM/DD/YY) | Claim Amount* |
|-----------------|-----------------|----------------------------|---------------|
|                 |                 |                            |               |
|                 |                 |                            |               |
|                 |                 |                            |               |
|                 |                 |                            |               |
|                 |                 |                            |               |
|                 |                 |                            |               |

\* Claims on first form submitted must include the portion that is the patient's responsibility PLUS the amount to be reimbursed.

By signing this form, I understand that benefits shall be paid in accordance with the guidelines and limitations established by the Board of Trustees.

| Participant's Signature | Date |
|-------------------------|------|
|                         |      |

**Instructions:** To receive reimbursement from the Sacramento Area Electrical Workers Health and Welfare Plan, you must complete ONE FORM PER PATIENT and submit the following information:  
**Copy of your Explanation of Benefits (EOB) from WHA, Aetna or Kaiser. (Receipts or Balance Due Statements from your doctor's office are not acceptable in lieu of the EOB.)**

PLEASE NOTE:

**Aetna PPO:** The Plan will reimburse your annual (calendar year) deductible actually incurred up to \$1,000.00 per individual/family member with a maximum of \$3,000.00 per family after you pay the first \$500 per member. You MUST allow up to 30 business days for reimbursement. All reimbursements for claims will be made payable to the participant.

**WHA HMO:** The Plan will reimburse up to \$1,750 per covered member (up to three per family) of the Hospital Inpatient Copayment after you pay the first \$250. Maximum reimbursement will be \$1,750 for four days of hospitalization, \$1,250 for three days, \$750 for two days, and \$250 for one day. The Plan will also reimburse \$250 per procedure for outpatient surgery, as well as \$50 per procedure for MRI, CT Scan, and MUGA. You MUST allow up to 30 business days for reimbursement. All reimbursements for claims will be made payable to the participant.

**Kaiser HMO:** The Plan will reimburse \$250 for Inpatient Hospital Charges and Outpatient Surgery Charges after you pay the \$500 Copayment.

After completion, please mail this form and all corresponding documentation to:

**United Administrative Services**  
**Sacramento Area Electrical Workers**  
 PO Box 5057  
 San Jose, CA 95150

If you have any questions, please call our office at (916) 923-0666

| FOR ADMINISTRATIVE USE ONLY |                 |      |      |
|-----------------------------|-----------------|------|------|
| Control ID                  | Processing Date | Disp | Init |
|                             |                 |      |      |