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TrustSecure™ Reimbursement Claim Form

Use this form to file a claim for reimbursement through your TrustSecure account. **(NOTE:** Please do not submit a claim form until you have at least \$100 in expenses.) Attach all appropriate receipts to this claim form and mail to the following address:

Educators Benefit Consultants, LLC, 3125 Airport Parkway, NE, Cambridge, MN 55008

Employer

Participant Name (Last, First, Middle Initial)

Social Security No.

Address (Street)

Phone Number (Including Area Code)

Address (City, State, Zip)

Unreimbursed Medical Expenses* (indicate premium costs on the reverse side of this form)

Date Expense Incurred (mm/dd/yy)	Expense Description	Person for Whom Expense Incurred	Net Amount
Attach appropriate receipt(s) and submit with this claim form.			Total \$

continued . . .



TrustSecure is administered on behalf of the WEA Trust by:
Educators Benefit Consultants, LLC, 3125 Airport Parkway, NE, Cambridge MN 55008
Toll-free: (888) 507-6053 Fax: (763) 552-6055 Web site: weatrustsecure.com

Premium Costs

Insurance	Monthly Premium Amount	Months Paid	Automatic Monthly Reimbursements (Circle one)		Total
Medical			Yes	No	
Dental			Yes	No	
Long Term Care			Yes	No	

- I certify that all expenses for which reimbursement is claimed by submission of this form were incurred by me or my eligible dependent(s) after becoming a participant in TrustSecure.
- I certify that the medical expenses incurred by me or my eligible dependent(s) are qualifying expenses as defined by the Internal Revenue Service Code. If these expenses are not qualified expenses, I understand that I will be liable for payment of all related taxes on all ineligible amounts paid out by the Plan.
- * I certify that the medical expenses claimed have not been reimbursed or cannot be reimbursed under any other health plan coverage or other type of tax-exempt medical reimbursement account.
- I take full responsibility for the accuracy and truthfulness of all the information I have provided.

Participant Signature

Date