UFCW TRUST
Working For Your Benefit

P.O. Box 4100 · Concord, CA 94524-4100
Telephone: (800) 552-2400 · Facsimile: (925) 746-7549
www.ufcwtrust.com

KAISER
REIMBURSEMENT CLAIM FORM

Kaiser reimbursements will be reviewed upon receipt of all required information and utilizing all current plan rules.

Participant ID #: _____

Spouse ID #: _____

Participant Name: _____

Spouse Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Patient Name:	**Date of Service:**	**Reimbursement Amount:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature of Participant: _____ **Date:** _____

Signature of Spouse: _____ **Date:** _____

Kaiser ID #: _____

Attach receipts from Kaiser

Mail form to address listed above