Whatcom County

DENTAL REIMBURSEMENT PLAN CLAIM FORM

For Plan Year JANUARY 1, 2017 through DECEMBER 31, 2017

There are 4 ways to submit a dental claim:

- Upload supporting documentation directly online or via the MyNavia phone app*****
- Fax claim and supporting documentation to (425) 709-7125 or toll-free (866) 831-6222
- Scan and email claim form and supporting documentation to: 105@naviabenefits.com
- Mail claim and documentation to: Navia Benefit Solutions P.O. Box 53250, Bellevue, WA 98015

****** *You must first be registered on the Participant Portal of our website to submit the claim online or via the phone app. If you have not registered yet, go to https://portal.naviabenefits.com/part/PortalRegistration.aspx and enter your last name, first initial, email address, company code (WHA), date of birth, and create a unique username. Once you've successfully registered, a temporary password will be emailed to you, which you must use to log-in for the first time. If you attempt to register and the system can't match what you're entering to the information on file, please contact Navia for further assistance.*

Section I - Employee Information

Name - Last, First, Middle Initial	Last 4 digits of SSN	Phone Number	
Address ❑*Check this box if your address needs to be updated*	City	State	Zip Code
Email Address ***see Section III*	**Annual Reimbursement Tier Structure per Enrollee** Dental: 100% of the first $250; 80% of the next 500; 50% of the next $1,700 Orthodontia: 70% of each payment ($1,500 lifetime maximum)		

Section II - Service Information

The services indicated below must have been incurred during the plan year shown at the top of this form. **Dental** services are incurred on the date the services are rendered and you must support your claim with an itemized statement verifying the date of service, type of service, cost, and the name of the patient receiving the service. **Orthodontia** services are considered to be incurred on the date a payment is made and you must submit proof of payment being made during the plan year. Itemize claimed expenses below by service date and patient.

IMPORTANT- Do not use your Health Care FSA debit card for dental or orthodontia expenses that are reimbursable under the Dental Plan. The Dental Plan is funded by Whatcom County while the card is only tied to the funds in your Health Care FSA. If you do use the card for an expense that's reimbursable under the Dental Plan you will need to remit payment to Navia to pay back your FSA before the funds can be transferred and the claim can be reimbursed properly from the Dental Plan.

Service Date	Dental or Orthodontia?	Patient Name	Relationship to Employee	Cost of Service

If you maintain a Health Care FSA, any residual amount that's not payable from this claim will automatically be entered into your FSA. If you do not wish to have the residual amount entered into your Health Care FSA, please indicate below.

❑ NO, please do not enter residual amount into my Health Care FSA

Does the claimant have other dental coverage?

❑ YES - If so, please provide an Explanation of Benefits (EOB) from the insurance carrier

❑ NO

Section III – Signature

To the best of my knowledge my statements on this claim form are complete and true. I understand that I am solely responsible for the sufficiency, accuracy, and veracity of claims and all information related to these claims submitted to my Dental Reimbursement Plan/HRA, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Dental Reimbursement Plan/HRA, I may be liable for the payment of all related taxes including federal, state or city income tax on amounts paid from the Dental Reimbursement Plan/HRA which relate to such expense. I am claiming reimbursement for eligible expenses under the Dental Reimbursement Plan/HRA incurred by myself, and/or my qualified spouse or dependents. Note: The IRS does not recognize Domestic Partners for purposes of receiving tax-favored health benefits. For further information please contact your employer. I certify that these expenses have not been reimbursed under this plan or by any other source and that they will not be reimbursed by any other source or insurance. ****By providing an email address**, I consent to receive all possible communications from Navia, agents, and subcontractors regarding the Plan via email. I may withdraw consent at anytime without charge by contacting Navia by phone, email, or mail. To update your email address contact Navia by phone, email, or mail. You have the right to receive paper version of an electronic document free of charge. Software requirements will be provided with each electronic document. I hereby authorize my Dental Reimbursement Plan/HRA to be reduced by the amount(s) shown above.

Participant's Signature **X**	Date