SOUTHWEST OHIO REGIONAL COUNCIL OF
CARPENTERS HEALTH AND WELFARE FUND
33 FITCH BLVD.
AUSTINTOWN, OHIO 44515
1-800-435-2388

MEDICAL REIMBURSEMENT FROM DOLLAR BANK ACCOUNT
Request for Reimbursement of Medical Expense Not Paid By The Health and Welfare Fund

EMPLOYEE NAME:____

ADDRESS:____

________________________PHONE NUMBER:________________

SOCIAL SECURITY NUMBER________________________

I am requesting payment for the following charges for which I have not been reimbursed, and for which I have not and will not be claiming a federal income tax deduction: **ALL RECEIPTS AND/OR CANCELLED CHECKS MUST BE ACCOMPANIED BY A ITEMIZED BILL. FOR PRESCRIPTIONS: RECEIPT FROM STORE WILL NOT BE ACCEPTED NEED RECEIPT FROM BAG.**

AMOUNT OF DEDUCTIBLE MET	$__________
AMOUNT OF CO-INSURANCE	$__________
VISION CARE(attach receipts & itemized bill)	$__________
DENTAL CARE(attach receipts & itemized bill)	$__________
OTHER EXPENSES	$__________
TOTAL	$__________

I hereby authorize payment for the above services for which I am requesting benefits:

☐ Payable to Provider ☐ Payable to Member

Please complete the above, attach a copy of your EOB's from the Health & Welfare Plan where applicable, and receipts showing payments were made for expenses **not** covered by the Health & Welfare Plan, sign and return this form to the above address.

Please call first to check the status of your account before filing a large dollar claim. **Please make a copy for yourself in the event of being lost.**

When you have Dollar Bank Credits in excess of three month's eligibility, those Credits may be used to reimburse you for certain medical expenses. When you receive reimbursement, your Dollar Bank is reduced by the amount of the Credits. The **deadline** for filing reimbursement for Medical Reimbursement claims is December 31st following the end of the Plan Year in which you incurred the claims expense(s).

EMPLOYEE SIGNATURE________________________DATE________________

Not valid unless signed and dated by Employee