I.B.E.W. LOCAL UNION 306

Supplemental Health Benefit Fund

33 FITCH BOULEVARD AUSTINTOWN, OHIO 44515 1-800-589-8041

AUTHORIZATION FOR DISBURSEMENT FROM MEDICAL REIMBURSEMENT ACCOUNT

REQUEST FOR REIMBURSEMENT OF MEDICAL EXPENSES

EMPLOYEE NAME ______________________________

ADDRESS ______________________________

______________________ PHONE NO. ______________

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:

AMOUNT OF DEDUCTIBLE $__________

AMOUNT OF CO-INSURANCE $__________

VISION CARE **(attach receipts)** $__________

DENTAL CARE **(attach receipts)** $__________

OTHER MEDICAL EXPENSES **(attach receipts)** $__________
(not covered by the Health & Welfare Fund)

SELF PAYMENT BILLING **(attach copy of billing)** $__________

☐ Check here if you elect to have your self-payment remitted directly to your health fund

Please complete the above, attach a copy of your EOB (Explanation of Benefits) 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:

I.B.E.W. LOCAL UNION 306
SUPPLEMENTAL HEALTH BENEFIT FUND
33 Fitch Boulevard
Austintown, Ohio 44515

All expenses submitted for a quarter (other than self-payments) will be reimbursed in the months of October, January, April, and July. For example, claims received during the months of July, August and September will be reimbursed in October. Please call first to check the status of your account before filing large dollar claims and **PLEASE MAKE A COPY FOR YOURSELF OF ALL CHARGES SUBMITTED IN THE EVENT OF LOSS**.

EMPLOYEE SIGNATURE ______________________ DATE ______________

Not valid unless signed and dated by Employee