I.B.E.W LOCAL 32
Voluntary Employee Benefit Association Plan

Office Location
33 Fitch Boulevard
Austintown, Ohio 44515

Phone: (330) 270-0453
Toll Free: 800-589-8041
Fax: (330) 270-0912

AUTHORIZATION FOR DISBURSEMENT FROM MEDICAL REIMBURSEMENT ACCOUNT

REQUEST FOR REIMBURSEMENT OF MEDICAL EXPENSES

EMPLOYEE NAME:____

ADDRESS:____

PHONE NUMBER:____________________

SOCIAL SECURITY NUMBER____________________________

AMOUNT OF DEDUCTIBLE MET	$____________
AMOUNT OF CO-INSURANCE	$____________
OTHER EXPENSES	$____________
TOTAL	$____________

Please complete the above, attach a copy of your EOB (Explanation of Benefits) from the Health & Welfare Plan where applicable.

Sign and return this form to:

I.B.E.W. LOCAL 32
VOLUNTARY EMPLOYEE BENEFIT ASSOCIATION PLAN
33 FITCH BLVD
AUSTINTOWN, OHIO 44515

EMPLOYEE SIGNATURE________________________ DATE__________________

Not valid unless signed and dated by Employee