

# **IBEW LOCAL 573 PERSONAL CARE ACCOUNT**

**33 Fitch Boulevard  
Austintown, Ohio 44515  
1-800-435-2388 (330) 270-0453**

## **AUTHORIZATION FOR DISBURSEMENT FROM PERSONAL CARE 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:

IBEW LOCAL 573 PERSONAL CARE ACCOUNT  
33 Fitch Boulevard  
Austintown, Ohio 44515

All expenses submitted for a quarter (other than self-payments) will be reimbursed in the months of March, June, September and December. For example, claims received during the months of September, October, and November will be reimbursed in December. 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\*\***