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:

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Austintown, Ohio 44515

All expenses received by the 15th of the month will be reimbursed at the end of that month. For example, claims received by January 15th will be reimbursed at the end of January. **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