

BANK PLAN REIMBURSEMENT FORM

THE CLEVELAND ASBESTOS WORKERS NO. 3 HEALTH & WELFARE PLAN
 33 Fitch Boulevard
 Austintown, Ohio 44515

Member's Name _____

Social Security No. _____

Address _____

Home Phone: _____

City, State, Zip _____

Cell Phone: _____

Fax: _____

Please attach bills, copy of cancelled checks and/or receipts for each itemized claim.
 Only send copies of bills and cancelled checks as the original will not be returned to you.

Date	Patient Name	Name of Provider of Service	Service or Illness	Member Total

MEMBER SIGNATURE _____

DATE _____

For Office Use Only

\$

Date Received _____

Total Amount Approved

Approved by Union Trustee _____

Total Available Funds

Approved by Employer Trustee _____

Total Paid

Date Paid _____