INSULATORS LOCAL 84
HEALTH CARE PLAN

33 Fitch Boulevard
Austintown, Ohio 44515
Phone: (330) 270-0453
Fax: (330) 270-0912

AUTHORIZATION FOR DISBURSEMENT FROM MEDICAL REIMBURSEMENT ACCOUNT

REQUEST FOR REIMBURSEMENT OF MEDICAL EXPENSES

EMPLOYEE NAME _____

ADDRESS _____

_____ PHONE NO. _____

SOCIAL SECURITY NUMBER _____

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)	$_____
TOTAL	$_____

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:

INSULATORS LOCAL 84 HEALTH CARE PLAN
33 Fitch Boulevard
Austintown, OH 44515

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