

*Ohio Conference of Plasterers and Cement Masons  
Health and Welfare Fund*

33 Fitch Boulevard • Austintown, Ohio 44515  
Telephone (330) 270-0453 • Toll Free 1-800-435-2388



**AUTHORIZATION FOR DISBURSEMENT FROM  
MEDICAL REIMBURSEMENT 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:

OHIO CONFERENCE OF PLASTERERS AND CEMENT MASONS  
HEALTH AND WELFARE FUND  
33 Fitch Boulevard  
Austintown, Ohio 44515

All eligible expenses submitted during a calendar month will be reimbursed the following calendar month. For example, claims received by the end of October will be reimbursed in November.  
**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\*\***