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 or itemized bills and receipts showing payments were made or copies of cancelled checks 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