SHEET METAL WORKERS LOCAL NO. 33 YOUNGSTOWN DISTRICT HEALTH & WELFARE FUND

Telephone (330) 270-0453
Toll Free 1-800-589-8041

Office Location
33 Fitch Boulevard
Austintown, Ohio 44515

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:

SHEET METAL WORKERS LOCAL 33 YOUNGSTOWN DISTRICT
HEALTH AND WELFARE FUND
33 Fitch Boulevard
Austintown, Ohio 44515

All expenses submitted for a quarter will be reimbursed in the months of March, June, September and December. Reimbursement requests must be received by the 15th of the month of each quarterly payout. **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