

International Heat & Frost Insulators Local #3 Health and Welfare Fund

33 FITCH BOULEVARD

AUSTINTOWN, OHIO 44515

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:

INTERNATIONAL HEAT & FROST INSULATORS
LOCAL #3 HEALTH & WELFARE FUND
33 Fitch Boulevard
Austintown, Ohio 44515

All expenses submitted for a quarter will be reimbursed in the months of January, April, July, and October. For example, claims received during the months of July, August and September will be reimbursed in October. 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****