PLUMBERS AND STEAMFITTERS LOCAL NO. 7 WELFARE FUND
Personal Account Reimbursement Form

Member Name:_____ **SS#:** _____

Address:_____ Office Use Only: _____

City/Zip: _____

Phone:_____ ☐ **Home**_____ ☐ **Cell**

E-mail Address: _____

Status: ☐ **Active** ☐ **Retired** ☐ **Inactive**

VERIFICATION: Please attach **original** itemized statements and receipt showing the paid expense.
Claims under this benefit must be submitted within 12 months from the date the expense was paid and **must total at least $200** combined. Claims submitted in the months of March and November may total less than $200.

Required Documentation:

- **Explanation of Benefits (EOB) statement from the health insurance company**
- **Itemized bill or receipt from provider of service for qualifying health related expenses that are not covered under any medical or dental plan**
- **Each EOB, bill, or receipt must include the name of person receiving the service; date and type of service; amount charged for service; provider information on the bill and/or receipt**

Please complete the claim form by providing a total for each applicable category and a grand total for the entire reimbursement requested. Claims must be received by **Friday** for a check to be processed on Thursday. Checks are processed every other week.

Categories:

$\_\_\_\_\_**Medical co-pays (1000)** **$**_____**Prescription Drug co-pays (1001)**

$\_\_\_\_\_**Dental self-paid receipts (2000)** **$**_____**Hearing (6000/6001)**

$\_\_\_\_\_**Vision (5000/5001)** **$**_____**Orthodontic (1999)**

$_____**Self-paid Health Insurance Premiums (1002)**

$_____**Other**_____

TOTAL AMOUNT REQUESTED FOR REIMBURSEMENT:

The Local 7 Welfare Fund reserves the right to request additional information to support this claim.
Insurance Frauds Prevention Act: The following statement is printed pursuant to Regulation 95 of the New York State Insurance Department: *"Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime."*

I certify that either I or my eligible dependent(s), as described in Section II., C. on page 6 of the Welfare SPD, have incurred these expenses, that I have not been previously reimbursed for these expenses, and that I am not eligible for reimbursement for these expenses through any other plan. Furthermore, I declare that I have not and will not deduct these expenses on my own or anyone else's federal income tax return.

Member's signature_____ **Date:** _____

Mail completed form to: Plumbers & Steamfitters Local 7 Welfare Fund
18 Avis Drive Latham, NY 12110
Phone: (518)785-3440
Fax: (518)785-9855