Roofers Local No.74/No.203 Health and Welfare Fund
Health Expense – Reimbursement Benefit Form

2800 Clinton Street
West Seneca, New York 14224

Phone: (716) 828-0488
Toll Free: (800) 905-0904
Fax: (716) 828- 0487

Member Name _____

Member Address _____

City _____ State _____ Zip code _____

SS # _____ Birth Date _____ Phone # _____

- **Multiple submissions may be made on one claim form.**
- **Total claim must total $75.00 Minimum.**
- **Attach all documentation.**
- **No claims will be processed unless FRONT and BACK of this form is completed in full.**

Are you or dependents covered for any benefits under any OTHER PLAN? ___Yes ___No
If Yes, please complete:

Name of Policy Holder _____ Date of Birth _____

Carrier Name _____ Phone # _____

Policy Number _____ Dependent Coverage ___ Yes ___ No

IF THIS CLAIM IS FOR A DEPENDENT, FILL IN THIS SECTION

Dependent's Name(s) _____ _____ _____

Date(s) of Birth _____ _____ _____ _____

Relationship _____ _____ _____ _____

Is dependent married? ___Yes ___No
Is dependent Employed? ___Yes ___No
Dependent children 19 or older, Is dependent full time student? ___Yes ___No
Is dependent covered under other insurance carrier listed above? ___Yes ___No

The participant must submit receipts and this form to receive reimbursement. Physicians or pharmaceutical Receipts, along with a copy of any applicable billing, must be submitted to receive reimbursement. This benefit will not reimburse the following items: amounts paid or eligible for payment under the Insurance portion of the Plan or other medical insurance health plans, Federal or State government programs and/or workers' compensation. Further, the Plan will not reimburse expenses which are payable, or should be payable by a third party who is responsible, or may be responsible, for causing your illness or injury.
(No expenses will be reimbursed unless they are filed within one (1) year of payment date)

I hereby certify that the information contained on this form is, to the best of my knowledge and belief, true and accurate, and each expense item is eligible for reimbursement in accordance with the IRS Publication 502 I understand I am responsible for the proof provided.

Signature of Member _____ Date _____

Documentation of Claims

(List each receipt separately)

Patient Name	Date of Payment Attach receipt	Type of Service (Dental, Co- pay, Deductible, Etc.)	Requested Amount	Amount Paid (Fund Office Use only)
		Total Amount Requested:		

Types of Eligible Services: Office Visit Co-pays, Dental Claims, Orthodontic Claims, Vision Claims, Prescription Co-pays, Chiropractic Claims, Annual Deductibles, Health insurance Premiums (I e COBRA, Direct Pay)

Receipts for payments of payments listed above, must accompany claims or provider statement.
No payment will be made if proof of payment and this form is not completed in its entirety.

Acceptable Proofs:
Copies of Provider statement showing date of service, claim amount and payment received
Copies of Prescription Receipts showing co-pay and drug name – cash register receipts unacceptable
Copies of Cancelled Checks – Front and Back
Copy of Explanation of Benefit (EOB), showing payment owed, along with proof of payment
Hand written receipts unacceptable

Please allow for up to 60 Days from date submission for Processing
All terms subject to change per claim record auditor