I.B.E.W. LOCAL 910 HEALTH AND WELFARE FUND

25001 Water Street, Watertown, New York 13601
Tel: (315) 782-5941, Fax: (315) 782-7343

PERSONAL ACCOUNT PLAN DISTRIBUTION CLAIM FORM

CLAIMANT DATA **SECTION 1**

Participant Name: _____ Social Security#: _____

Participant's Address: _____ Date of Birth: _____

_____

Individual (s) for whom documentation of reimbursable medical expense is attached:

NAME:	RELATIONSHIP TO PARTICIPANT	DATE OF BIRTH
1.) _____	_____	_____
2.) _____	_____	_____
3.) _____	_____	_____

DOCUMENTATION OF CLAIMS **SECTION 2**

Claims under this benefit may be submitted only if they total at least **$100.00**. Several bills may be added together in order to reach the **$100.00**. In the month of December, bills may be submitted to the Plan, regardless of the size.

Even if you have outstanding bills, the balance in your Individual Account may not be reduced below **$2000.00.**

TOTAL HEALTH EXPENSE APPLIED FOR: **$_____**

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 Plan 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

SECTION 3

I hereby certify that the information contained in this form is, to the best of my knowledge and belief, true and accurate, and each expense item is eligible for reimbursement. I understand that I am responsible for the proof provided, and if the expenses submitted are determined to be not eligible for reimbursement, then the reimbursement I received will be taxable to me.
The Trustees, or the designee, have sole and absolute discretion to determine whether the expenses submitted are eligible for reimbursement.

AUTHORIZATION TO RELEASE HEALTH INFORMATION SECTION 4

I hereby authorize the I.B.E.W. Local 910 Health and Welfare Fund to disclose and discuss my individually identified health information with _____ (insert name of person authorized to discuss and receive information) concerning the above bills and the treatment mentioned therein. I understand that after the information is disclosed, it may no longer be protected by Federal Privacy Regulations and the recipient might not treat it as confidential and may re-disclose it. I understand that this authorization is voluntary and that I have the right to refuse to sign this authorization; I am entitled to receive a copy of this authorization; I have the right to revoke this authorization at any time by notifying the Fund Office in writing; the revocation is only effective after it is received by the Fund Office and it will not effect any actions taken by the Fund Office based on the authorization and prior to receipt of the revocation.

This authorization will expire upon payment of the itemized expenses.

_____ Date: _____
Signature of participant/patient or person
submitting expense reimbursement form

_____ Date: _____
Signature of person granting authorization

FOR FUND OFFICE ONLY

AMOUNT PAID:

DATE CHECK ISSUED:

CHECK NUMBER: