ROOFERS, WATERPROOFERS LOCAL 241 HEALTH ACCOUNT
REIMBURSEMENT FORM

Claims under this benefit must be submitted within 24 months from the date the expense was incurred and must total at least $100.

Participant Name: _____ SS# _____

Address: _____City/State: _____

Zip Code: _____ Phone: _____ Status: ☐ Active ☐ Retired ☐ Inactive

VERIFICATION: Please attach original bills or original itemized statements and receipts showing paid expense.

For Health Care:

- Explanation of Benefits (EOB) statement from health insurance company and
- 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 the following Friday.

Categories:

$_____ Medical co-pays

$_____ Deductible

$_____ Dental self-paid receipts

$_____ Hearing

$_____ Prescription Drug co-pays

$_____ Self-paid Health, Dental, Vision, And Rx Premiums

$_____ Vision

$_____ Other

TOTAL AMOUNT REQUESTED FOR REIMBURSEMENT:

$_____.____

The Roofers, Waterproofers Local 241 Health and 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 the 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 VI., Health Care Reimbursement Benefit, on pages 9-11 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.

Participant's Signature _____ Date: _____

Mail completed form to: Roofer, Waterproofers Local 241 Insurance and Welfare Funds Office
890 Third Street
Albany, NY 12206
Phone: (518) 489-3919