SUPPLEMENTAL BENEFIT ACCOUNT (SBA) REIMBURSEMENT FORM

Return Completed Form to:
Michiana Area Electrical Workers Health and Welfare Fund
6525 Centurion Drive
Lansing, MI 48917

Name:_____ **Member ID or SS#** _____
Include the First, Middle and Last Name, as applicable.

Address: _____ **Telephone Number:**_____
Type the Street Number, Directional Code, Street Name, Way Code and Unit Number, as applicable. (NNN)NNN-NNNN

City, State, Zip_____ ☐ Please check here if this is a new address
Type the City Name, Type the two-letter State abbreviation, Type the five-digit ZIP code

Enclosed claims are for (check only one) ☐ **Self** ☐ **Spouse** ☐ **Son** ☐ **Daughter**

Dependent's Name _____ **Date of Birth**_____

Is dependent covered by another health insurance plan? ☐ **Yes** ☐ **No**

Instructions for claims submission:
Supporting documentation must accompany this Reimbursement Form: For each **itemized bill**, submit receipt or explanation of benefits (EOB), indicating deductible, co-insurance and any amounts not paid from any Medical, Dental or Vision Plans under which you and/or your eligible dependents are covered. ***Please itemize your expenses below and attach receipts in order***. Retain copies of supporting documentation for your records as the submitted documents will not be returned.

NOTE: Bills/receipts must clearly indicate the patient name, physician name, date of service, etc. In addition, if your bill/receipt is for a co-payment, this must be clearly indicated on your bill/receipt. Please circle or high-light the amount you are requesting reimbursement for.

-Missing information may cause a delay in the processing of your claim(s)-

Service Date	Description of Charges	Provider Name	Amount Requested
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			
11)			
12)			
13)			
14)			
15)			
	Total Expenses:		$0.00

I certify that either myself and/or my eligible dependents have incurred the expenses for which reimbursement is claimed from the Supplemental Benefit Account.

_____ _____
Signature of Participant Date

All eligible reimbursement requests for less than $300 will be paid to the Employee only.
Eligible reimbursements in excess of $300 are payable to a provider, when submitted with an assignment of benefits