

SUPPLEMENTAL BENEFIT ACCOUNT REIMBURSEMENT REQUEST FORM

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

Participant's Name _____ Member Identification Number _____

Home
Address _____
Type your complete street address here

Telephone Number _____ Date of Birth _____

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

When Filing Claims

1. Supporting documentation must accompany this Request Form. Supporting documentation includes any of the following:
 - Explanation of Benefit Form(s) indicating deductible, co-insurance and any amounts not paid from any Medical, Dental or Vision Plans under which you and/or any of your eligible dependents are covered.
 - Itemized bills from doctor, dentist or other supplier for recognized medical expenses not covered by your Medical/Dental/Vision Plans.
2. Retain copies of supporting documentation for your records, as those submitted will not be returned.
3. Send completed Reimbursement Request Form and supporting documentation to the Fund Office at the address above.

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

Employee's Signature

Date

All eligible reimbursement requests for less than \$500 will be paid to the Employee only. Eligible reimbursements in excess of \$500 are payable to a provider, when submitted with an assignment of benefits.