Plumbers & Steamfitters Local 267 Insurance
MEDICAL REIMBURSEMENT FORM

Section 1 - Must be completed by the participant

Name: _____ **Social Security Number:** _____

Address: _____ **Date of Birth:** _____

City: _____ **State:** _____ **Zip Code:** _____

Section 2 - Benefit Election - Must be completed by the participant

I certify that I have read and understand the information on this form. I understand that I can only receive a benefit from this Plan if I am eligible for a benefit and have submitted the **required paperwork**. I certify that I have incurred the expense for the claim submitted below. I understand that I am solely responsible for the accuracy of the information.

Eligibility for Benefits-Reimburse for
Medical, Dental, Vision

No POMCO EOB'S
No Collection Letters
No Life Ins Premiums

NO PRE TAX PAYROLL DEDUCTIONS FROM OTHER INS PLANS.

ONLY ACTUAL PAID INVOICES FOR SERVICES –Invoices must be marked paid.

Amount of Benefit - Please CHOOSE THE FOLLOWING

I ELECT TO RECEIVE THE FOLLOWING AMOUNT FOR MEDCIAL REIMBURSEMENT:
Must be over $100.00
OR $_____

PLEASE PAY DOCTOR DIRECT $_____
Must be over $100.00 for each Doctors bill

Date: _____ 2015 _____
Participant's Signature

Section 3 - Must be signed by Fund Representatives

Trustee: _____ **Date:** _____/_____/2015

Trustee: _____ **Date:** _____/_____/2015

Fund Manager: _____ **Date:** _____/_____/2015

Please complete & return to:

Plumbers & Steamfitters Local 267 Insurance Fund
107 Twin Oaks Dr.
Syracuse, New York 13206
FAX 315-701-2947