

I.B.U. of the Pacific National Health Benefit Trust

**SUPPLEMENTAL CLAIM FORM  
(for non-covered charges)**

Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Insured's Identification Number \_\_\_\_\_

Charges over usual and customary and certain not covered charges may be reimbursed from your supplemental account, provided funds are available.

Include a copy of your itemized bill, your Carrier's (Trust, Kaiser or HMSA) explanation of benefits (EOB) sheet indicating the paid charges and the amounts to be reimbursed for your out of pocket expenses.

DO NOT use this form if you have Trust dental or vision claims, as you will receive a monthly recap letter to claim out of pocket expenses.

I am requesting \$ \_\_\_\_\_ in reimbursement from my supplemental account. Attached is a copy of my receipts or EOB's.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Return form to: IBU Health Trust  
Attn: Supplemental  
PMB #116, 5331 S Macadam Ave, Ste 258  
Portland, OR 97239