

**BAC LOCAL 23 NORTH SHORE CHAPTER HEALTH & WELFARE FUND
SUPPLEMENTAL HEALTH REIMBURSEMENT ACCOUNT CLAIM FORM**

Member Name: _____

Social Security #: _____

Member Address _____

Phone Number: _____

<i>Supplemental Health Reimbursement/Expense Claims</i>					
Date Expense Incurred (mm/dd/yy)	Name of Service Provider	Description of Expense	Name of Person Who Incurred Expense	Relationship To Member	Net Amount
Total Medical Expense Claimed					\$

READ CAREFULLY: The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned is solely liable for payment of all related taxes including federal, state, or city income tax and penalties on the amount paid from the Plan which relates to such expense.

Participant Signature

Date

**Note: Form must be signed in order to process the claim.

Mail or Fax Claim Form and Supporting Documents to:

**BAC Local 23 North Shore Chapter
Health and Welfare Fund
9525 Sweet Valley Drive
Valley View, OH 44125**

Fax: (216) 520-1663