I.B.E.W. LOCAL UNION 306
Supplemental Health Benefit Fund

PO Box 1129 Troy, MI 48099-1129 1-800-435-2388
e-mail: flexclaims@benesys.com Fax: 1-248-556-2597

AUTHORIZATION FOR DISBURSEMENT FROM MEDICAL REIMBURSEMENT ACCOUNT

REQUEST FOR REIMBURSEMENT OF MEDICAL EXPENSES

EMPLOYEE NAME _____

ADDRESS _____

_____ PHONE NO. _____

SOCIAL SECURITY NUMBER _____

I am requesting payment for the following charges for which I have not been reimbursed, and for which I have not and will not be claiming a federal income tax deduction:

AMOUNT OF DEDUCTIBLE $_____

AMOUNT OF CO-INSURANCE $_____

VISION CARE (**attach receipts)** $_____

DENTAL CARE (**attach receipts**) $_____

OTHER MEDICAL EXPENSES (**attach receipts)** $_____
(not covered by the Health & Welfare Fund)

SELF-PAYMENT BILLING (**attach copy of billing**) $_____

☐ Check here if you elect to have your self-payment remitted directly to your health fund

Please complete the above, attach a copy of your EOB (Explanation of Benefits) from the Health & Welfare Plan where applicable, and receipts showing payments were made for expenses not covered by the Health & Welfare Plan, sign and return this form to:

I.B.E.W. LOCAL UNION 306
SUPPLEMENTAL HEALTH BENEFIT FUND
PO Box 1129
Troy, MI 48099-1129
or
E-MAIL TO:
flexclaims@benesys.com
or
FAX: 1-248-556-2597

PLEASE MAKE A COPY FOR YOURSELF OF ALL CHARGES SUBMITTED IN THE EVENT OF LOSS.

EMPLOYEE SIGNATURE_____ DATE _____

Not valid unless signed and dated by Employee