

# **IBEW LOCAL 573 PERSONAL CARE ACCOUNT**

**33 Fitch Boulevard**

**Austintown, Ohio 44515**

**1-800-435-2388**

**(330) 270-0453**

## **AUTHORIZATION FOR DISBURSEMENT FROM PERSONAL CARE 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:

IBEW LOCAL 573 PERSONAL CARE ACCOUNT

**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\*\***