

Youngstown Area Electrical Welfare Fund



3660 Stutz Drive, Suite 101
Canfield, Ohio 44406
Phone: 330-370-0453

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:

YOUNGSTOWN AREA ELECTRICAL WELFARE FUND

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****