INSULATORS LOCAL 84
HEALTH CARE PLAN

33 Fitch Boulevard
Austintown, Ohio 44515
Phone: (330) 270-0453
Fax: (330) 270-0912

AUTHORIZATION FOR DISBURSEMENT FROM MEDICAL REIMBURSEMENT ACCOUNT

REQUEST FOR PAYMENT OF HOSPITALIZATION PREMIUMS

EMPLOYEE NAME _____

ADDRESS _____

PHONE NO._____

SOCIAL SECURITY NUMBER _____

ACTIVE SELF-PAYMENT $_____

OR

RETIREE SELF-PAYMENT $_____

Please complete the above, attach a copy of your premium notification, sign and return this form to:

INSULATORS LOCAL 84 HEALTH CARE PLAN
33 Fitch Boulevard
Austintown, OH 44515

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