

IRON WORKERS LOCAL UNION NO. 207

Voluntary Employee Benefit Association Plan

PO Box 1129
Troy, MI 48099-1129

Phone: 1-800-435-2388
Fax 1-248-556-2597

e-mail: flexclaims@benesys.com

AUTHORIZATION FOR DISBURSEMENT FROM VOLUNTARY EMPLOYEE BENEFIT ASSOCIATION PLAN

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:

IRON WORKERS LOCAL UNION NO. 207
VOLUNTARY EMPLOYEE BENEFIT ASSOCIATION PLAN

PO Box 1129
Troy, MI 48099-1129

or

E-MAIL TO:

flexclaims@benesys.com

or

FAX: 1-248-556-2597

PLEASE CALL FIRST TO CHECK THE STATUS OF YOUR ACCOUNT BEFORE FILING LARGE DOLLAR CLAIMS AND **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****