

OHIO BRICKLAYERS HEALTH & WELFARE PLAN

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AUTOMATIC MEDICAL REIMBURSEMENT FORM FROM DOLLAR BANK ACCOUNT

"Your Bricklayers' Fund Making a Difference"

REQUEST FOR AUTOMATIC REIMBURSEMENT OF DEDUCTIBLE AND CO-PAYMENT FROM RESERVE ELIGIBILITY ACCOUNT (DOLLAR BANK) FOR MEDICAL CHARGES NOT PAID BY THE HEALTH & WELFARE PLAN

PLEASE PRINT:

PARTICIPANT NAME: _____

ADDRESS: _____

SOCIAL SECURITY NO. _____

AUTOMATIC MEDICAL REIMBURSEMENT

Yes, I want to have my Dollar Bank Account automatically deducted for any deductible and co-payment amounts which I may owe to health care providers and paid directly to the provider. I understand that this automatic payment from my Dollar Bank will only be made as long as I have a sufficient balance in my account per the rules of the Plan. This automatic reimbursement will remain in force until revoked by me in writing or no longer allowed under the rules of the Ohio Bricklayers Health & Welfare Plan.

PARTICIPANT SIGNATURE: _____ DATE _____