PLUMBERS & PIPEFITTERS MEDICAL FUND
7130 Columbia Gateway Drive, Suite A, Columbia, MD 21046
Phone: 1-800-741-9249

2026
MEDICAL REIMBURSEMENT ALLOWANCE
HEALTH CARE REIMBURSEMENT REQUEST FORM

1. Type or print on the Employee Section below.

2. A. Active Members: Accumulate at least $400.00 in expenses **incurred between January 1 and December 31, 2026** to be reimbursed before submitting a claim to the Fund. Claims that are under $400 must be submitted after December 31, 2026, but before March 31, 2027.

   B. Non-Medicare Retired Members: Accumulate at least $400.00 in expenses **incurred between January 1 and December 31, 2026** to be reimbursed before submitting a claim to the Fund. Claims that are under $400 must be submitted after December 31, 2026, but before March 31, 2027. (If you are requesting reimbursement for a self-payment, it is not necessary to submit a copy of your self-payment check.)

   C. MEDICARE ELIGIBLE RETIRED MEMBERS: Accumulate at least $600.00 in expenses **incurred between January 1 and December 31, 2026** to be reimbursed before submitting a claim to the Fund. Claims that are under $600 must be submitted after December 31, 2026, but before March 31, 2027. (If you are requesting reimbursement for a self-payment, it is not necessary to submit a copy of your self-payment check.)

3. Supporting documentation **must** accompany this request form. Supporting documentation includes the following:

   - a copy of the **EXPLANATION OF BENEFITS** from Plumbers and Pipefitters Medical Fund.
   - an **ITEMIZED BILL** from the provider
   - acceptable proof that you paid the expenses and they were not reimbursed by this or any other Plan such as a **CANCELLED CHECK, STORE RECEIPT, CREDIT CARD BILL, etc.**

4. Retain copies of supporting documentation for your records, as those submitted to the Fund will not be returned.

5. Send completed claim form and supporting documentation directly to Plumbers & Pipefitters Medical Fund, 7130 Columbia Gateway Drive, Suite A, Columbia, MD 21046.

NOTE: ANY ITEMS FOR WHICH YOU ARE REIMBURSED CANNOT BE CLAIMED AS DEDUCTIONS ON YOUR FEDERAL INCOME TAX RETURN.

EMPLOYEE SECTION

NAME	SOCIAL SECURITY NO.	
ADDRESS	PHONE	
CITY	STATE	ZIP CODE

FUND OFFICE SECTION

CHECK NO:	AMT:	DATE:	CLAIM NO:

I certify that either I and/or my eligible dependent(s) have incurred the expenses for which reimbursement is claimed from the Medical Reimbursement Allowance and I further declare that I have not and will not deduct these expenses on my individual Income Tax Return. I understand that I may not assign this payment to another person – the Fund will only make payment to me.

Employee Signature _____ Date _____