

*Ohio Conference of Plasterers and Cement Masons
Health and Welfare Fund*

3660 Stutz Drive, Suite 101 • Canfield, Ohio 44406
Telephone: (330) 779-8860 • Toll Free 1-800-435-2388

**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:

OHIO CONFERENCE OF PLASTERERS AND CEMENT MASONS
HEALTH & 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****