I.B.U. of the Pacific National Health Benefit Trust & All Alaska Longshore Health & Welfare Trust

SUPPLEMENTAL CLAIM FORM
(for non-covered charges)

Name_____

Address_____

City, State, Zip_____

Insured's Identification Number_____

Charges over usual and customary and certain not covered charges may be reimbursed from your supplemental account, provided funds are available.

Include a copy of your itemized bill, your Carrier's (Trust, Kaiser or HMSA) explanation of benefits (EOB) sheet indicating the paid charges and the amounts to be reimbursed for your out of pocket expenses.

DO NOT use this form if you have Trust dental or vision claims, as you will receive a monthly recap letter to claim out of pocket expenses.

I am requesting $_____ in reimbursement from my supplemental account. Attached is a copy of my receipts or EOB's.

Signature _____

Date_____

Return form to: IBU Health Trust
Attn: Supplemental
PMB #116, 5331 S Macadam Ave, Ste 258
Portland, OR 97239