



Health and Welfare Fund

6281 Youngstown-Warren Rd., Suite 240
Niles, Ohio 44446
330-652-3475 FAX 330-652-3513
Toll Free 1-800-362-9354

MILLWRIGHT & MACHINE ERECTORS LOCAL UNION 1241

REQUEST FOR REIMBURSEMENT OF MEDICAL EXPENSES

Please complete and attach a copy of your Explanation of Benefits (EOB) and send to the address above.

PLEASE PRINT OR TYPE:

Employee's Name: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone Number: _____

Employee Social Security Number: _____

I hereby request that payment for the attached Medical Expenses be deducted from my Eligibility Account. I understand that my Eligibility Account cannot be used for payment of these expenses if it would reduce my balance below three (3) months of eligibility cost. I also certify that these expenses were incurred by me or an eligible dependent of mine under the Fund and have not been reimbursed by any other Insurance Plan.

Signature: _____

Date: _____

In lieu of an Explanation of Benefits (EOB), attach a copy of your receipt for other Medical Expenses not covered by the Health Insurance.

DISBURSEMENT DATES: If request received at the Fund office by the 10th of every month check cut on the 15th of the month. If request received at the Fund office by the 25th of every month check cut on the 30th of the month.

7/2006