Plumbers and Pipefitters Local Union #94 Health & Welfare Fund

P.O. Box 1129
Troy, MI 48099-1129
Phone (800) 435-2388
Fax (248) 731-5603

REIMBURSEMENT CLAIM FORM

E-mail: local94DV@benesys.com

(Dental/Vision Benefit, Medical Reimbursement Account, Self-Payments)

Instructions: Check off the type of reimbursement you are requesting. Please complete **ONE FORM per claim/per individual**, along with the following information:

Reimbursement for:	**Requirements:**
☐ Dental/Vision Services	Attach copy of the itemized billing. This billing must include the date of service, procedure code for services performed as well as the patient's name. This is your Dental/Vision Plan that reimburse eligible expenses up to a maximum payment of $2,000 per Family/Per Calendar year.
	☐ Dental/Vision balance - Please pay any remaining balance using my MRA funds.
☐ Medical Reimbursement	A copy of the Explanation of Benefits form (EOB) from your medical carrier which shows the member responsibility and matches the amount being requested below. Receipts showing payment was made for expenses not covered by the Health and Welfare Plan. (Please note: balance due statements are not acceptable.)
IMPORTANT NOTICE:	**A submission of a claim that has already been reimbursed under the Dental/Vision Plan may result in the suspension of your Benny Card.**
☐ Self-Payment	A copy of the Self-Payment Notice must be attached; your self-payment will be remitted directly to your health fund.

Member's Name: _____ Member's SS# or Alternate ID: _____

Address: _____

Phone Number: (Home) _____ (Work)_____

Patient Name: _____ Relationship: _____

Type of Service	**Provider Name**	**Date of Service**	**Amount of Claim**
_____	_____	____/____/____	_____
_____	_____	____/____/____	_____
_____	_____	____/____/____	_____

By signing this form, I understand that benefits shall be paid in accordance with the Plumbers and Pipefitters Local Union 94 Health & Welfare Fund Account requirements and limitations established by the Board of Trustees. **Note: Unreimbursed medical, dental, vision and prescription expenses are subject to limitations specified in your Summary Plan Description.** *(See the reverse side of this form for a brief description of covered benefits)*

Member's Signature: _____ Date: _____

*****Not valid unless signed and dated by employee*****