BOSTON PLASTERERS' & CEMENT MASONS' LOCAL #534
HEALTH REIMBURSEMENT ARRANGEMENT CLAIM FORM

PLEASE COMPLETE THIS FORM IN ITS ENTIRETY INCOMPLETE FORMS WILL BE RETURNED.

Complete the information below for out of pocket Health Care Expenses incurred by you and your eligible dependants. Eligible dependants are defined under the Local #534 Health & Welfare Plan. **You must provide an itemized bill and receipt from an independent third party such as an insurance company, doctor or other health care provider, indicating the name of patient, date(s) of service or supply and the type of service or supply. Canceled checks, balance forward statements, or generic cash receipts cannot be used for claim purposes.** The minimum claim submission for payment is $100. Please sign and date the form and enclose the appropriate documentation.

Participants Name: (Last, First, Middle Initial)		SS#
Home Address:		
City	**State**	**Zip**

Reimbursement for Health Care Expenses

If you have more expenses than the spaces provided, please add a separate sheet, itemizing all expenses following the format below.

Patient/Dependant's First & Last Name	Birth Date	Relationship to Participant	Date of Service	Name of Service Provider	Out-of-Pocket Amount
					$
					$
					$
					$
					$
					$
					$
					$
					$
				Total	$

Participant Signature Required

I certify that all listed expenses have not been reimbursed by any other source, nor will they be reimbursed by any other source. In addition, I certify that these expenses were incurred for eligible members of my family or me, and they have not been reimbursed from any other health insurance coverage. I understand that I alone am fully responsible for the sufficiency and accuracy of all the information I provide relating to this reimbursement request.

Participants' Signature:_____ Date_____