IRON WORKERS DISTRICT COUNCIL OF WESTERN NY & VICINITY SUPPLEMENTAL BENEFIT FUND
REQUEST FOR PAYMENT REIMBURSEMENT FORM

CHECK HERE IF CHANGE OF ADDRESS: ☐ Local Number: _____ Effective 11/21

Last Name_____First Name_____

Address:_____ City:_____State:_____Zip: _____

Employee SS Number: XXX-XX-_____Contact Number: ( ) _____

1. **Are you retired from the Iron Working trade? Yes ☐ No ☐**
2. **Are you and your dependent(s) currently enrolled in the Iron Workers Health Insurance Plan or another Employer-Sponsored Health Insurance Plan? Yes ☐ No ☐**

Patient name	Relationship to subscriber	Provider	Date of service	Claim amount	Did you have insurance at the time of service?
				$	Yes ☐ No ☐
				$	Yes ☐ No ☐
				$	Yes ☐ No ☐
				$	Yes ☐ No ☐
				$	Yes ☐ No ☐
				$	Yes ☐ No ☐
				$	Yes ☐ No ☐
			Total	$	

Reimbursement for Insurance Premiums

Are you (short-pay) paying for additional hours? Yes ☐ No ☐ Enter Amount Requested: $_____

***Must have a minimum of 100 hours per Work period to choose this option. ***

Are you paying for Self-Pay or COBRA? Yes ☐ No ☐ Enter Amount Requested: $ _____

Circle the months you would like coverage for:

January	February	March	April	May	June
July	August	September	October	November	December

***All payments are due on or before the first day of each month's coverage is requested.**

Are you requesting reimbursement for health or dental insurance premium paid to a plan other than Iron Workers? Yes ☐ No ☐ Enter Amount Requested: $_____

***Insurance premiums must be post-tax.

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Claim Form Instructions

Who Can File a Claim: Only the Plan participant, custodial parent, or the surviving spouse can sign the claim form and reimbursements will only be made payable to the member whose name appears on the account or the qualified beneficiary. Payments cannot be made to the provider.

What Expenses Can Be Claimed: Only expenses for which services have been rendered or premiums paid, if applicable, can be claimed for reimbursement.

Documentation Required:

If you have any type of insurance:

- Include photocopies of the Explanation of Benefits (EOB) with this claim form.

If you do not have insurance:

- Itemized bills should include:
  Provider name & address, patient name, date of service, description of services provided & billed charges.
- Balance forward statements do not meet the requirements for acceptable documentation for claims where the patient does NOT have insurance.

Insurance premiums:

- Copy of the insurance premium billing notice **AND** proof of payment (i.e., copy of front and back of the check, credit card confirmation, etc.) for qualified insurance policies.

Time Frame for Claim Submission: Claims must be submitted within two (2) years from the date services were provided. The Fund Office will not return original documentation.

Account Balance: ***Active Members-*** In no event will any benefit be paid from your account if such payment would reduce your balance below $150.00.

Send completed Request for Payment Reimbursement Form and supporting documentation to:

Iron Workers District Council of Western NY and Vicinity Supplemental Benefit Fund
3445 Winton Place, Suite 238
Rochester, NY 14623-2950

Contact the Fund Office at (585) 424-3510 with any questions.

I certify that the expenses for which I am requesting reimbursement meet all the following conditions listed below: They were incurred for service or supplies by my eligible dependents or me. I have not been reimbursed for these expenses in any other way. Including but not limited to; another HRA/Supplemental Account, Topping Off Fund, or other insurance plan. I understand the reimbursement of these expenses should be requested and made only after I have collected all benefit payments available from all plans under which my eligible dependents and I are covered. I further certify that I have not deducted or will not deduct any of the expenses reimbursed through my Account on my individual income tax return. I understand that reimbursement will be made in accordance with the guidelines set by the Internal Revenue Service and the provisions of the plan. I accept all responsibility for the proper treatment of benefits under this plan with respect to eligibility, income tax reporting and liability. Any person who knowingly and with the intent to defraud or deceived any insurance company, files a statement of claim containing any materially false, incomplete, or misleading information is guilty of a crime and may be liable for substantial civil penalties. **Active Members-** In order to be eligible for employer contributions to be made to the Supplemental Benefit Fund on your behalf, you must be enrolled in the health benefit provided by the IWDC of Western NY & Vicinity Welfare Plan, or in another employer-sponsored health plan that has been certified to the Plan Administrator as "minimum value," as defined under the Affordable Care Act (collectively referred to as "group coverage").
Effective July 1, 2017, your eligible dependents must also enroll in Group Coverage to participate in the Individual Account.

Member/Custodial Parent/Surviving Spouse's Signature: _____

Date: _____