Iron Workers District Council of Western New York & Vicinity Supplemental Benefit Fund
3445 Winton Place, Suite 238
Rochester, NY 14623
Phone: (585) 424-3510 / Fax: (585) 424-3722

Authorization for Automatic Rollover for Payment of Eligible Out-of-Pocket Expenses

Note: If you or any of your eligible dependent(s) have any type of other coverage (medical, dental, vision, prescription, or hearing you **are not** able to enroll in this program. If you obtain other coverage after enrolling in this agreement, you must contact the Fund Office to be removed from Automatic Rollover.

I authorize the Iron Workers District Council of Western New York and Vicinity Supplemental Benefit Fund ("The Fund") to withdraw funds from my Supplemental Account to reimburse me for any eligible health related expenses incurred by myself or my eligible dependents.
Local 33: Including but not limited to, charges by any dentist, optometrist/ophthalmologist, or optical dispensing service which is not covered under the Welfare Plan.
Locals 9 & 440: Including but not limited to, charges by any doctor, dentist, optometrist/ophthalmologist, hospital, or any health facility, pharmacy, optical dispensing service, or hearing aid provider which is not covered under the Welfare Fund.

I understand that in no event will any benefits be paid from my account if such a payment would reduce the balance in my account below ONE HUNDRED FIFTY DOLLARS ($150.00).

- I certify that expenses for which reimbursement is requested from the Supplemental Benefit Fund have been incurred by me and/or my eligible dependents and are not payable by any other plan (i.e.: health insurance plan, HRA, FSA, and Topping Out Fund).
- I further declare that I have not and will not deduct these expenses on my federal, state, or local income tax returns.
- Any person who knowingly and with intent to defraud or deceive 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.
- I understand that this authorization will remain in effect until written notification to cancel rollover service is received by the Fund Office.

Name: _____ Date: _____
(Print)

Signature_____ Local: _____

Social Security Number: XXX-XX-___ ___ ___ ___

Note: If a claim is denied under the Welfare Fund, you will be required to manually submit your claim directly to the Supplemental Plan for reimbursement. It will not automatically roll over from your account. **Example**: A claim which was not paid by the Welfare Fund because you reached your annual vision or dental maximum allowance would need to be manually submitted to the Supplemental Fund.