Local 73 Health & Welfare Fund
Individual Medical Account Reimbursement Benefit

P.O. Box 911
Oswego, NY 13126
Phone: (315)343-1808
FAX: (315) 343-4184

Individual Medical Account Guidelines for Withdrawal

Below is a list of guidelines required when submitting claims for reimbursement of medical expenses from the Individual Medical Account. Please review these before submitting in order to avoid delay or denial of your reimbursement.

1. Only charges for medical expenses beginning May 1, 2002, not covered under the Insurance Plan may be submitted. These include dental, eye, immunizations, prescriptions and any balance owed after insurance payment.

2. Charges must be submitted to primary and secondary insurance carriers you may have prior to submission to the Individual Account.

3. The following is required when requesting withdrawal from the Individual Account:
   a.) Copy of detailed bill
   b.) Proof of payment. E.g. receipt or copy of cancelled check.
   c.) Copy of Explanation of Benefits from primary and/or secondary insurance carriers.
   d.) Completed and signed Individual Medical Account Reimbursement form.

4. Withdrawal cannot exceed the balance of your Individual Account. If charges exceed the balance the reimbursement will be limited to amount reflected in your account and cannot be resubmitted in the future.

5. Charges will be processed for withdrawal once a month. Submissions should be sent in monthly. Please be advised you are not obligated to submit each month. You may let your Individual Account build up for future expenses you may incur. You do not lose your unused balance.

6. Charges submitted for withdrawal must total at least $25.00 in order to be processed.

7. Medical expenses must be submitted within one year of the date of service.

8. If you desire to use this account to self-pay for your coverage under Local 73 Health & Welfare Fund, you must sign and return the prescribed form to authorize that election. The rules for eligibility under Local 73 Health & Welfare Fund are divided into three month periods, so if you are out of coverage, you will remain out of coverage for three months, therefore we will remove three months of premium from your account. If you are short of dollar to pay for three months you will not be allowed to remove the money from this account for your coverage.

LOCAL 73 HEALTH & WELFARE FUND
P.O. Box 911, Oswego, NY 13126
Individual Medical Account Reimbursement Benefit

Section 1 **Claimant Data**

Participant Name _____ Social Security #_____

Participant's Address _____

Individual(s) for whom documentation of reimbursable medical expense is attached:

Name	Relationship to Participant	Date of Birth
1)_____	_____	_____
2)_____	_____	_____
3)_____	_____	_____

Section 2 **Documentation of Claims**

Claimant and Description of expense	Date Incurred	Amount sought for Reimbursement*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

***Please read the following: Attach copy of medical insurance Plan Explanation of Benefits Statement or Attach copy of medical Bills supporting each listed item of expense, and include proof of payment.**

This plan will not reimburse the following items: Amounts paid or eligible under other medical insurance, health plans, federal, state or government programs, workers compensation, or any other health insurance policy.

Section 3 **Participant Certification**

I hereby certify that the information contained in this form is, to the best of my knowledge and belief, true and accurate, and each expense item is eligible for reimbursement. I understand that I am responsible for the proof provided, and if the proof submitted is in fact determined to be not eligible, then the reimbursement I received will be taxable to me.

Date:_____ Signature:_____