M

CLAIM FORM FOR PERSONAL BENEFIT SUPPLEMENTAL MEDICAL/DENTAL DISBURSEMENT

Effective 1/1/2005

1. NAME & ADDRESS: _____

   _____

   _____

2. PHONE # _____ SOCIAL SEC. #: XXX-XX-_____

3. TYPE OF SERVICE: _____
   (MEDICAL/DENTAL/VISION)

4. DOCTOR / PROVIDER NAME: _____

5. PATIENT NAME: _____

6. SERVICE DATE(s): _____

7. **PAY TO PROVIDER** _____ PAY TO MEMBER_____

MUST INCLUDE PROVIDER TAX ID NUMBER & ADDRESS TO PAY DIRECT

Effective 7/1/2015 claims may be submitted only if they total at least $100.00 when either paid to the provider or the member.

SECTION 14.6 Payment of Personal Benefit:

You are eligible to receive benefits from your Individual Account if the following applies…
c) You or one of your dependents has expenses for medical care not otherwise paid for by the Welfare Fund. Unless services and payment have already been rendered and paid for, the benefits will be payable directly to the medical provider in the amount not otherwise reimbursed or paid by the Welfare Fund. Benefits can be paid until your Individual Account balance has been reduced to zero."…

Statement: I have read eligibility requirements for medical/dental benefits and hereby apply for payment. I understand that a distribution for this purpose is not reportable to me as taxable compensation for Federal and State purposes whether paid to myself or paid to a service provider. **(rev 1/1/2021)**

DATE: _____ PRINT NAME: _____

SS#: XXX-XX-_____ SIGNATURE: _____

OFFICE USE ONLY

Available Balance: _____

Claim Amount: _____

Service Provider Fed ID#: _____

Name: _____

Street Address: _____

City: _____

State/Zip: _____