Roofers Local #195 Health and Accident Fund

(IAP)Health Expense Benefit Reimbursement Form

6200 State Route 31
Cicero, NY 13039

Phone: (315) 699-1388
Fax: (315) 699-1390

1. Member Name_____ Birth Date_____ SS#:_____

2. Member Address_____ Phone: (___)_____

Multiple submissions per patient may be made on one claim form. Attach all documentation. No claims will be processed unless page 2 of this form is completed in full!

3. Are you or your dependents covered for any benefits under any other plan? _____ Yes _____No
If yes, please complete:

Name of Policy Holder_____ Date of Birth_____

Carrier Name_____ Phone: #_____

Policy Number_____ Dependent Coverage: _____Yes _____No

IF THIS CLAIM IS FOR A DEPENDENT, FILL IN THIS SECTION

4. Dependent's Name_____ Birth Date_____

5. Relationship_____ Is Dependent Married? _____Yes _____No
Is Dependent Employed? _____Yes _____No

6. For Dependent Children are 19 or older, is patient a full time student? _____Yes _____No

7. Is Dependent Covered under Policy listed in #3 above? _____Yes _____No

The Participant must submit Original physicians or pharmaceutical receipts and this form to receive reimbursement, along with a copy of any applicable billing. No Faxed copies will be accepted. This Plan will not reimburse the following items: amounts paid or eligible for payment under the Insurance portion of the Plan or other medical insurance, health plans, federal or state government programs and/or workers' compensation. Further, the Plan will not reimburse expenses which are payable, or should be payable, by a third party who is responsible, or may be responsible, for causing your illness or injury, unless you have signed the appropriate forms and cooperated with the Fund, all as set forth in the Summary Plan Description at the Sections entitled "General Exclusions" and "Right of Recovery" (Per the Plan Summary Description: Claims older than five years from date of service are not eligible for reimbursement; Claims incurred before the participant became a Participant in The Plan, are not eligible for reimbursement. You and your beneficiaries are not permitted to withdraw money for the Health Expense Benefit if the withdrawal would cause your account to contain an insufficient amount to pay the premiums for at least two (2) months of Health Insurance Benefit coverage at the rate in effect when you apply for the withdrawal. Reimbursement, if any, will be made directly to the Participant.)

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 expenses submitted are determined to be not eligible for reimbursement, then the reimbursement I received will be taxable to me. The Trustees, or their designee, have the sole and absolute discretion whether the expenses submitted are eligible for reimbursement.

_____ _____
Signature of Member Date

Authorization to Release Health Information

I hereby authorize the Roofers Local 195 Health and Accident Fund to disclose and discuss my individually identified health information to the enclosed receipted provider(s) concerning the above bills and the treatment mentioned therein. I understand that after the information is disclosed, it may no longer be protected by Federal Privacy Regulation and the recipient might re-disclose it. I understand that this authorization is voluntary and that I have the right to refuse to sign this authorization; I am entitled to receive a copy of this authorization; this authorization will expire upon payment of the itemized expenses; I have the right to revoke this authorization at any time by notifying the Fund Office in writing; the revocation is only effective after it is received by the Fund Office and it will not effect any actions taken by the Fund Office based on the authorization and prior receipt of the revocation.

_____ _____
Signature of Person Granting Authorization Date

Documentation of Claims

(List each receipt separately if more space is needed, file additional claims)

Patient Name	Date of Service	Type of Service (dental, co-pay, deductible, etc.)	Requested Amount	**Amount Paid (Fund Office use only)**
		Total Amount Requested:		

Types of Eligible Services: Office Visit Co-pays, Dental Claims, Orthodontic Claims, Vision Claims, Prescription Co-pay's, Chiropractic Claims, Podiatry Claims, Annual Deductibles, Health Insurance Premiums (i.e. COBRA, Self/Direct Pay)

Claim and receipts for payments of claims listed above, must accompany this request.
No payments will be made if proof of payment is not enclosed and this form is not completed in its entirety.
Please allow for up to 60 Days from date of submission for processing (per law).

Acceptable Proofs: **Please mail original documents – No faxed copies accepted.**

Provider statement showing date of service, claim amount and payment received.
Original Pharmacy Prescription Receipts showing co-pay amount or Pharmacy print-out.
Copies of Cancelled Checks.

Please make a copy of this completed form and attachments for your personal records, before submission.
This information will not be returned to you.