SUPPLEMENTAL BENEFIT ACCOUNT REIMBURSEMENT REQUEST FORM

Return Completed Form to:
Flint Plumbing & Pipefitting Industry Health Care Fund
Supplemental Benefit Account
6525 Centurion Drive
Lansing, MI 48917

Participant's Name ________________________________ Member ID or SS#__________________________

Home Address ____
Street City State Zip Code

Telephone Number (_____) _____________________ Date of Birth ___________________________________

Enclosed claims are for (check only one) Self Spouse Son Daughter

Dependent's Name ____________________________________ Date of Birth ___________________________

Is dependent covered by another health insurance plan? Yes No

When Filing Claims

Eligible expenses include reimbursement of self-payments, hearing aids, vision services, laser eye surgery, co-payments and/or benefits in excess of the benefit maximum for preventive services only and dental benefits (including orthodontics) above what is currently covered in the Plan

NOTE: You must be eligible on the date services are incurred and have a balance of $1,000 or more in your SBA account on the date services are incurred.

All claims must be filed within one (1) year from the date of service

1. **Supporting documentation must accompany this Request Form. Supporting documentation includes the following:**
   - **Itemized bills from doctor, dentist or other supplier for recognized medical/dental/vision expenses not covered by your Medical/Dental/Vision Plans.**
   - **Explanation of benefits (EOB) for each medical/dental/vision expense submitted**
   - **Proof of payment (evidence sufficient to the Trustees that the amount has been paid by the participant)**
2. **Retain copies of supporting documentation for your records, as those submitted will not be returned.**
3. **Send completed Reimbursement Request Form and supporting documentation to the Fund Office at the address above.**

-Please itemize expenses on the reverse side of this form-

I certify that either I and/or my eligible dependents have incurred the expenses for which reimbursement is claimed from the Supplemental Benefit Account.

_______________________________________ _______________________________

Employee's Signature Date

SBA reimbursement form 03/15

Flint Plumbing & Pipefitting
INDUSTRY HEALTH CARE FUND

Participant Name:____________________________

ID or SS#:__________________________________

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NOTE: Claim is not acceptable unless both pages of the claim form are submitted

NOTE: Bills/receipts must clearly indicate the patient name, provider name, date of service, etc. In addition, if your bill/receipt is for a co-payment, this must be clearly indicated on your bill/receipt. Please circle or high-light the amount you are requesting reimbursement for.

-Missing information may cause a delay in the processing of your claim(s)-

Service Date	Description of Charges	Provider Name	Patient Name	Amount Requested
1)				
2)				
3)				
4)				
5)				
6)				
7)				
8)				
9)				
10)				
11)				
12)				
13)				
14)				
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19)				
20)				
21)				
22)				
23)				
24)				
25)				
26)				
27)				
28)				
29)				
30)				
	Total			