Construction & Metal Trades Divisions

The Steamfitters' Industry Fund Office

27-08 40th Avenue, 2nd Floor
Long Island City, NY 11101-3725
(212) 465-8888
www.steamfitters.com
FundOffice@steamny.com

WELFARE FUND

APPLICATION FOR HEALTH REIMBURSEMENT ACCOUNT

PLEASE DO NOT EMAIL THIS FORM

- **This application along with the supporting documentation must be mailed or delivered to the Fund Office.**
- **All information on this application must be completed.**
- **Use this form only to be reimbursed for the following expenses: COBRA, Dental, Hospital, Medical, Long Term Care Insurance Premium, Prescription Drugs, Medicare Part B & D Premiums, Over-The-Counter (OTC) Medicinal Products, Vision, Hearing, Other Health Insurance or Assisted Living Medical Costs.**
- **Only claims less than one year old from the date of service or purchase date are eligible for reimbursement.**
- **Reimbursements for dependents are only allowed for your dependents listed in the Welfare Fund.**
- **You and your spouse or over-age 18 dependent must both sign and date the application on the reverse side (if the claim is for an under age 18 dependent the dependent signature is not required).**
- **You must submit a copy of your medical or dental Explanation of Benefits and retail or home delivery pharmacy co-pay receipts.**
- **For out-of-network claims, you must submit Explanation of Benefits and an itemized bill with proof of payment.**
- **Please take advantage of Direct Deposit so you can receive your benefit check electronically. You can download a form on steamfitters.com under the forms section or call the Fund Office at 212-465-8888 to have one sent.**

Book Number _____

Name _____

_____ Home phone _____ Mobile _____ E-mail

Name of patient: _____

Claim is for: ☐ SELF ☐ Family _____ (PLEASE SPECIFY RELATIONSHIP)

TYPE OF BENEFIT: (CHECK ONE OR MORE BOXES)

☐ Medical	☐ COBRA	☐ Prescription Drugs
☐ Long Term Care Insurance	☐ Vision	☐ Medicare Part B or D
☐ Hospital	☐ Hearing	☐ Assisted Living Medical Costs
☐ Dental	☐ OTC Medicinal Products	

PARTICIPANT PROTECTED HEALTH INFORMATION AND FUND TRANSFER AUTHORIZATIONS

I authorize the Welfare Fund and/or Security Benefit Fund, its agents and business agents to disclose any of the specific protected health information relative to this claim if either Fund may need to, in order to process this application. I understand that this authorization will expire one year from the date I sign this application unless I revoke it sooner. I understand I have the right to revoke it at any time.

I also authorize that if this claim is for an amount which exceeds my account balance in the Health Reimbursement Account, the necessary amount from my Security Benefit Fund account can be transferred to the Health Reimbursement Account so that this claim can be paid in, or as close to as possible, the full amount of the submitted claim.

Signature of Participant:_____ **Date:**_____

SPOUSAL OR OVER-AGE 18 DEPENDENT PROTECTED HEALTH INFORMATION AUTHORIZATION

I, the spouse or over-age 18 dependent of the participant listed on reverse side authorize the Welfare Fund and/or Security Benefit Fund, its agents and business agents to disclose any of the specific protected health information relative to this claim if either Fund may need to, in order to process this application. I understand that this authorization will expire one year from the date I sign this application unless I revoke it sooner. I understand I have the right to revoke it at any time.

Signature of Spouse or Over-Age 18 Dependent:_____