PAINTERS DISTRICT COUNCIL NO. 4 HEALTH & WELFARE FUND MEDICAL EXPENSE REIMBURSEMENT FORM

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To be reimbursed for medical expenses, two types of documentation are usually acceptable to the Trustees.

First, you must submit your claim under any insurance plan under which the person receiving the medical service is covered - your own, your spouse's and/or your dependent's health, dental, vision care and medical plans. This will result in the insurer sending an explanation of benefits (EOB). You may attach the EOB as documentation of an unreimbursed medical expense.

Second, for unreimbursed medical expenses not covered by insurance and not documented by an EOB, you may submit a statement from the provider which indicates: name of the recipient of the service; date of the service; description of the service; cost of the service; and name, address, tax ID number of the provider and ***proof of payment*** *(no canceled checks). For medicines or drugs, you must provide a receipt with an Rx number and the name of the purchaser or patient.*

In order to be reimbursed for medical expenses, you must be currently enrolled in group health insurance through the Fund or through your spouse's employer.

Eligible expenses shall be determined in accordance with IRS Publication 502.

Section A: To be completed by Employee

Employee Name (Print) _____ Social Security Number _____

Home Address _____ Date of Birth _____

Home Phone _____ Marital Status _____

Section B: To be completed if submitted expenses are for Spouse or Dependent

Name	**Date of Birth**	**Relationship**

Section C: Reimbursement Account Expenses

Individual	Description of Expenses	Date of Service	Expense Amount

TOTAL _____

Section D: Authorization

I hereby certify that I am claiming reimbursement only for eligible expenses incurred during the Plan Year and for eligible Plan Participants/Dependents. I certify that these expenses have not and will not be reimbursed under this or any other benefit plan and will not be claimed as an income tax deduction. I request that the Plan reimburse me the amount requested.

_____ _____

Participant's Signature Date