

MIDWEST OPERATING ENGINEERS WELFARE FUND
FAMILY SUPPLEMENTAL BENEFIT CLAIM FORM

MEMBER'S NAME: _____

MEMBER'S SOC. SEC. # _____

MEMBER'S ADDRESS: _____

PLEASE NOTE:

- Expenses that may be reimbursed are those expenses you or your eligible dependent have which are not covered or not paid by any other portion of the Midwest Operating Engineers Welfare Fund or any other plan. However, expenses which are applied to your individual deductible or out-of-pocket amounts are not eligible for reimbursement.

- You must attach an itemized receipt from the doctor, dentist or other supplier which identifies the person receiving the service or a copy of the Explanation of Benefits denying the charge. The documentation that you submit to the Fund Office ***must identify all amounts paid by you on behalf of this claim.*** Keep copies of your receipts or benefits statements for your records. Those you submit with your claim will not be returned.

- The member must have been eligible at the time the expense is incurred.

- Active and Retired members are eligible for this benefit.

- Your claim must be received by the Fund Office no later than one year from the date of service.

I certify that either I and/or my eligible dependents have incurred the expenses and received the services for which reimbursement is claimed from the Family Supplemental Benefit. The expenses submitted for reimbursement are the actual fees I/we have been charged. I declare that I have not and will not deduct these expenses on my individual Income Tax Return. I hereby authorize my physician, and/or any other provider of service, to provide the Midwest Operating Engineers Health & Welfare Fund with any information deemed necessary, by that Fund, to adjudicate this claim.

No assignment will be accepted. All payments will be made to the member.

MEMBER'S SIGNATURE: _____

DATE: _____