

Roofers Local #195 Health and Accident Fund
(IAP)Health Expense Benefit Reimbursement Form

7706 Maltlage Drive
Liverpool, NY 13090

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

