

Toledo Electrical Welfare Fund

Opt Out Request for Reimbursement

Name: _____ Social Security #: _____

Instructions:

Fill in the necessary information for health care expenses incurred by you or your eligible dependents for which you request reimbursement. Expenses covered under medical insurance plans must be submitted to those plans for reimbursement. **You must attach a copy** of the Explanation of Benefits you receive from the insurance carrier along with this Request for Reimbursement. Expenses not covered under medical plans must be accompanied by a bill or receipt with a full explanation of the expense.

Date Incurred	Name of Individual Incurring Expense	Total Expense	Amounts Paid by Other Plans	Unreimbursed Expense
_____	_____	\$ _____	\$ _____	\$ _____
_____	_____	\$ _____	\$ _____	\$ _____
_____	_____	\$ _____	\$ _____	\$ _____
_____	_____	\$ _____	\$ _____	\$ _____
_____	_____	\$ _____	\$ _____	\$ _____
_____	_____	\$ _____	\$ _____	\$ _____
_____	_____	\$ _____	\$ _____	\$ _____

I hereby request payment from the Toledo Electrical Welfare Fund for the unreimbursed expenses indicated above.

I certify that I will not claim these expenses as an income tax deduction and that the expenses with the requirements of the Plan.

Signature: _____ Date: _____