TOLEDO ELECTRICAL WELFARE FUND
SUPPLEMENTAL FRINGE BENEFIT FUND (SFBF/VEBA)
AUTOMATIC REIMBURSEMENT FORM
419.666.4450 Phone 419.666.5410 Fax

Name: _____ SSN / UID #: _____
(Member's Information- Please Print) (Member's Information)

Instructions:
By completing the following form, you will be authorizing the Toledo Electrical Welfare Fund to automatically reimburse you for any out of pocket expense that the fund knows of when providing you benefits. For example, if you have a medical claim and the Fund applies a $100 deductible, the Fund will automatically reimburse you for the $100. The fund will only reimburse you up to the amount you have in your Supplemental Fringe Benefit Fund account.

The Fund will be able to provide this service for medical and dental. You will still have to file for reimbursement for prescription drug co-pays, vision expenses, self payments and out of pocket health care expenses that you do not receive an explanation of benefits from the Fund Office.

All Contributions after 9/27/04 (October Work Month) are for Type 2 Benefits. I authorize the SFBF to transfer monies from Type 2 to Type 1, if needed, so that I can be reimbursed for Type 1 Benefits.

You may not want this service if your spouse has other coverage (or a reimbursement plan like this one) for medical or dental.

Check one box:

Automatic Medical & Dental Reimbursement

☐ I hereby request the Toledo Electrical Welfare Fund use my SFBF/VEBA account to automatically reimburse me for out of pocket medical and dental expenses up to the amount in my SFBF/VEBA account. These expenses will not be paid for by other plans and I will not claim these expenses as an income tax deduction.

☐ I hereby request to be taken **OFF of the automatic** reimbursement for the SFBF/VEBA. I only want to be reimbursed when requested.

Member's Signature Date

Return to: Toledo Electrical Welfare Fund, P.O. Box 60408, Rossford, OH 43460