INSURANCE REIMBURSEMENT CLAIM FORM

419.666.4450 office 419.666.5410 fax

Name: ____________________________Social Security #: ____________________
(Member's Information) (Member's Information)

You should use this form if you have other insurance primary and TEWF is your secondary insurance (ex: for prescription co-pays). If you have other primary insurance, medical and dental claims should be sent from your provider with original claim and your explanation of benefits. Do not submit those claims on this form.

If TEWF is your primary insurance, you should use this form if you paid for something in full and it has not went through TEWF Insurance. If it is a medical or dental claim, please have provider submit claim to the insurance for processing.

Instructions:

Fill in the necessary information for Health care expenses incurred by you or your eligible dependents for which you request reimbursement.

Itemize all reimbursement requests below. No credit card receipts, actual invoice showing what was purchased and date of service. For prescription reimbursement: If you do not have a printout from the Pharmacy for your reimbursement of Rx co-pays, you must list individually each prescription below and attach the actual prescription receipt showing patient's name, date of service, prescription name and co-pay.

Date Incurred	Name of Individual Incurring Expense	Your Out-of-Pocket Expense
		$
		$
		$
		$
		$
		$
	TOTAL	$

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

____

Member's Signature **Date**

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