Opt Out Request for Reimbursement

Toledo Electrical Welfare Fund
P.O. Box 60408
Rossford, OH 43460
419.666.4450 office 419.666.5410 fax

Member's 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.

You may submit expenses for reimbursement which are incurred during the plan year which runs from January 1 through December 31. You will have 60 days after the end of the Plan Year to submit any expenses for reimbursement of that Plan Year

Date Incurred	Name of Individual Incurring Expense	Total Expense	Amount Paid by Other Plans	Amount Requested for Reimbursement
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$
		$	$	$

I hereby request payment from the Toledo Electrical Welfare Fund for the amount requested for reimbursement indicated above.

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

_____

Member's Signature Date