INSURANCE REIMBURSEMENT CLAIM FORM

419.666.4450 - phone 419.666.5410 - fax claims@electricalfunds.org - email

Name: _____ Social Security #: _____
(Member's Information) (Member's Information)

USE THIS FORM: if you have other insurance primary and want Toledo Electrical Welfare Fund ("TEWF") to consider any non-covered charges as your secondary insurance. NOTE: If you have other primary insurance, your healthcare provider should submit their claim along with the primary insurance explanation of benefits directly to TEWF as your secondary insurance.

USE THIS FORM: If TEWF is your primary insurance, and you have paid for something in full because the healthcare provider refused to submit a claim to insurance. Otherwise, if it is a medical or dental claim, please have the provider submit their claim to TEWF for processing.

Instructions:

Fill in the necessary information for health care expenses incurred by you or your eligible dependents for which you request reimbursement. List all reimbursement requests below. No credit card receipts. Include an itemized invoice showing what you purchased and when. The statement needs to include the patient's name and diagnosis, the provider name and tax I.D. number, and a description of the service or supply.

Date Incurred	Patient Name	Your Out-of-Pocket Expense
		$
		$
		$
		$
		$
		$
	TOTAL	$

I certify that the above information is true and correct to the best of my knowledge, and that I will not claim these expenses as an income tax deduction.

Member's Signature **Date**

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