TOLEDO ELECTRICAL WELFARE FUND
SUPPLEMENTAL FRINGE BENEFIT FUND (SFBF/VEBA)

AUTOMATIC MEDICAL & DENTAL REIMBURSEMENT ELECTION FORM

Phone 419-666-4450 Fax 419-666-5410 Email veba@electricalfunds.org

Name: _____ SSN / UID#: _____

(Member's Information-Please Print)

Last four of your social security number or your TEWF 6-digit Member ID on your medical ins. Card

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.

NOTE: If you, your spouse or any of your dependents have secondary insurance, this option is not available to you. It is your responsibility to let the Fund Office know if you, your spouse or any of your dependents under your insurance has any secondary (or tertiary if applicable) insurances after TEWF/FrontPath and TEWF/Delta Dental Insurance.

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 (secondary or tertiary insurances)** 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

Submit form by fax, email or mail to TEWF, P.O. Box 60408, Rossford, OH 43460