FOX VALLEY LABORERS HEALTH AND WELFARE FUND
2371 BOWES ROAD, SUITE 500, ELGIN ILLINOIS 60123-5523 (847) 742-0900

FAMILY SUPPLEMENTAL BENEFIT CLAIM FORM

MEMBER'S NAME: ____________________________ **SSN:** __________________________

MEMBER'S ADDRESS: ____

____

TELEPHONE NO: ____

PATIENT NAME: ____

RELATIONSHIP: ______________________________ **SSN:** __________________________

PLEASE NOTE:

- Expenses that may be reimbursed are those expenses you or your eligible dependent incur that are not considered for benefit payment under the Welfare Plan or any other group plan.
- Expenses applied to your calendar year deductible or co-pay amounts are not eligible for reimbursement.
- Expenses not recognized by the IRS as legitimate health care expenses are not eligible for reimbursement.
- You must complete one form for each patient, for each submission.
- You must attach itemized receipts for each date of service from the provider of service that identifies the patient receiving the service or a copy of the Explanation of Benefit Statement denying the charge. Keep copies of your receipts or benefit statements for your records as they will not be returned.
- Patient must be eligible under the Welfare Plan at the time the expense is incurred.
- You must submit your claim no later than one year after the date the expense is incurred.

I elect Benefits under the Family Supplemental Benefit to be payable:

_______ To me (member)

_______ To the provider of service

(If no election is made, benefits are automatically payable to the member)

________________________________ ________________________________
Member's Signature Date

Revised 09/05/2014
S:\Website\Forms\MOVE 09 2014\FAMILY SUPPLEMENTAL BENEFITS FORM-ENGLISH 09 2014.doc