RETURN COMPLETED FORM TO:

SHEET METAL WORKERS' LOCAL 265, HEALTH & WELFARE FUND
205 Alexandra Way, Carol Stream, IL 60188-2080
Phone (630) 668-7260, Fax (630) 668-7338
web: www.smw265funds.org • email: benefits@smw265funds.org

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HEALTH REIMBURSEMENT ARRANGEMENT RETIREE CLAIM FORM
(OVER AGE 65)

MEMBER INFORMATION

Name of Member ______________________ Date of Birth ____________

Home Address ______________________

City ____________ State ______ Zip Code ______ Telephone No. (____) ____________

Social Security No. XXX - XX - ____________

INSURANCE INFORMATION (Other Than Medicare)

Do you **or** your dependents have **ANY** other health insurance? ☐ YES ☐ NO If YES please supply:

1) Name of the person insured ______________________ Relationship to Employee: ____________
2) Insured person's Social Security No. ____________ Date of Birth ____________ Policy No. ____________
3) Insurance company name ______________________ Telephone No. (____) ____________
4) Address, City, State, Zip ______________________

DEPENDENT INFORMATION - If claim is for a Dependent

Name of Dependent ____________ Relationship to Employee ____________ Date of Birth ____________

Dependent's Social Security No. XXX - XX - ____________

Check Items Which Apply:

☐ Medicare Part B and/or Part D premium (indicate months requesting): ____________

☐ Pharmacy charges (submit itemized pharmacy receipts and/or a printout from the pharmacy)

☐ Dental, Hearing or Vision Charges, not payable by other insurance (submit itemized bill)

☐ Dental, Hearing or Vision Charges, payable by other insurance (submit itemized bill & other insurance EOB)

☐ Medicare Charges (submit the Medicare EOB and the Supplemental Plan's EOB, if you have a Supplemental Plan)

☐ Other (Please specify): ____________

INSURED SIGNATURE

I hereby certify the above statements are true and complete to the best of my knowledge and belief. I authorize the release, when requested by the Trustees or their representative, of any facts and/or related records concerning the injury, illness, or treatment (including mental/nervous and substance abuse) of myself or my dependents. A photocopy of this authorization shall be considered as effective and valid as the original.

Signature ______________________ Dated ____________ 20 ____

If claim for dependent over 17, Dependent's Signature ______________________ Dated ____________ 20 ____