CENTRAL NEW YORK LABORERS' HEALTH AND WELFARE FUND
7051 Fly Road East Syracuse, New York 13057-9659
Telephone Number: (315) 434-9305
Fax Number: (315) 437-8627
www.cnylaborers.com

RETIREE MEDICAL EXPENSE ACCOUNT CLAIM FORM

Member Name: _____ Telephone Number: _____

Address: _____ Social Security No: _____

_____

Show total charges you are claiming. Attach itemized statement(s) from the provider(s), and corresponding Explanation of Benefits from the insurance company. The itemized statement(s) must describe the service provided and the name of the patient. If claiming health insurance premiums, payment verification must be submitted.

Service Date	Patient's Name	Provider Name	Amount Claimed
		Total:	

The claimed amount must total a minimum of $100.00. In December of each calendar year, you may submit claims even if the total amount does not equal $100.00.

I certify the health premium(s) claimed are not paid with pre-tax dollars.

I certify that either my eligible dependent(s) or I has/have incurred the expenses for which reimbursement is requested under the Retiree Medical Expense Account provided by the Central New York Laborers' Health and Welfare Fund. Further, that the amount claimed in whole or in part has not been paid or is not covered by any other insurance or health program, third party, flex plan, etc.

Signature: _____ Date: _____

** The dates of service claimed cannot have occurred more that eleven months prior to the time of this submission. **