Railroad Maintenance and Industrial Health and Welfare Fund

2725 West Monroe Street
Springfield, IL 62704
(800)-258-6534 or (217)-787-2923

FAMILY SUPPLEMENTAL BENEFIT CLAIM FORM

PARTICIPANT'S NAME: _____

PARTICIPANT'S Social Security #: _____

PARTICIPANT'S ADDRESS: _____

_____

PATIENT'S NAME: _____ **DATE OF BIRTH** _____

PLEASE NOTE:

- Expenses that may be reimbursed are those expenses' you or your eligible dependents have which are not covered or not paid by any other portion of the Railroad Maintenance and Industrial Health and Welfare Fund or any other plan. However, expenses which are applied to your individual deductible or out-of-pocket amounts are not eligible for reimbursement.
- You must attach an itemized receipt from the doctor, dentist or other supplier which identifies the person receiving the service and/or a copy of the Explanation of Benefits Statement denying the charge. Keep copies of your receipts or benefit statements for your records. Those you submit will not be returned.
- The member must have been eligible at the time this expense is incurred.
- Your claim must be filed with the Fund Office no later than twelve (12) months following the date on which the claim is incurred.

I certify that either I and/or my eligible dependents have incurred the expenses for which reimbursement is claimed from the Family Supplemental Benefit and I further declare that I have not and will not deduct these expenses on my individual Income Tax Returns.

No claims will be accepted via facsimile. No assignment will be accepted. All payments will be made to the member. No claim will be considered until paid receipts showing the provider of service has been paid in full are received in the Fund office.

MEMBER'S SIGNATURE: _____ **DATE:** _____