LOCAL 30
MUNICIPAL ACTIVE EMPLOYEES BENEFIT FUND

William M. Lynn - Chairman of the Board
Darren M. Turton - Fund Administrator

2023 - SUPPLEMENTAL BENEFIT ACCOUNT REQUEST FORM - $1,000.00 ANNUAL MAXIMUM ALLOWANCE

1. Type or print information (items 1 through 6) on the Member Section below.
2. Enter total amount for which claim is being made in the appropriate section. The minimum reimbursement amount is $100.00. Any claims below $100.00 will be held until the minimum level is reached.
3. Supporting documentation must accompany this request form. Supporting documentation includes the following:
   - Explanation of Benefit Statement(s) indicating deductibles, co-insurance or amounts in excess of usual and customary charges from any medical/dental plan(s) under which you and/or any of your eligible dependents are covered, or **if the expenses are not covered under your medical/dental plan**, itemized bills from doctors, dentists, pharmacy or other suppliers for insured expenses.
   - Proof of payment
4. Retain copies of supporting documentation for your records.
5. Send completed claim form and supporting documentation to Christine Callahan at the Fund Office.

NOTE: ANY ITEMS FOR WHICH YOU ARE REIMBURSED CANNOT BE CLAIMED AS DEDUCTIONS OR CREDITS ON YOUR FEDERAL INCOME TAX RETURNS.

1. Members Name	2. Social Security Number	3. Patient's Name
4. Relationship ☐ SELF ☐ SPOUSE ☐ DEPENDENT	5. Type of Service	6. Provider's Name(s)

UNREIMBURSED HEALTH CARE EXPENSES FOR 2023 MUST BE SUBMITTED NO LATER THAN MARCH 31, 2024

	Date of Service	Claim Amount to be Reimbursed.
Deductible	________	$________
Coinsurance/Co-payments	________	$________
Other	________	$________
	Total	$________

I certify that either I and/or my eligible dependents are covered for Medical benefits under the New York City Health Benefits Program and have incurred the expenses for which reimbursement is claimed from the Supplemental Benefit Account and have received no other reimbursement for these expenses and I further declare that I have not and will not deduct these expenses on my individual income tax returns. No assignment will be accepted. All payments will be made to the member.

Member Signature ______________________ Date

ANNUITY • HEALTH AND WELFARE
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