BOILERMAKERS LOCAL 83
SUPPLEMENTAL HEALTH & WELFARE FUND
CLAIM FORM

Managed for the Trustees by:
TIC International Corporation
6525 Centurion Drive • Lansing, MI 48917
Telephone (517) 321-7502 • Fax (517) 321-7508

This form will cover claims for the period of **January 1, 2024 through June 30, 2024.** The form must be completed, signed and submitted to the Fund Office by **August 31, 2024** in order to receive benefits. Checks will be issued in **October 2024.**

PARTICIPANT INFORMATION

Name: _____ SSN: _____ Date of Birth: _____

Mailing Address: _____ ☐ Check here if new address

City: _____ State: _____ Zip: _____ Phone: (_____) _____

INSURANCE PREMIUM REIMBURSEMENT REQUEST

(Select type of coverage)

Name of Insurance Company	Monthly Premium Amount	Number of Paid Months	Total	Medicare Supplement	Employer Group Policy	Individual Policy
_____	_____	_____	$ 0.00	☐	☐	☐

Please list the family members covered under the policy:

1.Name _____ Date of Birth _____ Medicare Eligible(Y/N) _____

2.Name _____ Date of Birth _____ Medicare Eligible(Y/N) _____

3.Name _____ Date of Birth _____ Medicare Eligible(Y/N) _____

4.Name _____ Date of Birth _____ Medicare Eligible(Y/N) _____

(Select type of coverage)

Name of Insurance Company	Monthly Premium Amount	Number of Paid Months	Total	Medicare Supplement	Employer Group Policy	Individual Policy
_____	_____	_____	$ 0.00	☐	☐	☐

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3.Name _____ Date of Birth _____ Medicare Eligible(Y/N) _____

4.Name _____ Date of Birth _____ Medicare Eligible(Y/N) _____

TOTAL REIMBURSEMENT REQUEST: $ 0.00

SIGNATURE

Disclaimer: I hereby certify that all information on this form is true. All documentation submitted with or pertaining to this form has been photocopied from original bills and/or checks and has not been altered. If any document related to this form has been altered or falsified in any way, I hereby waive my rights to any future benefits from the Supplemental Health & Welfare Fund.

_____ _____

(Signature of Plan Participant) (Date)

INSTRUCTIONS FOR FILLING OUT CLAIM FORM ARE ON THE REVERSE SIDE

ALL PREMIUMS MUST BE PAID TO THE INSURANCE COMPANIES PRIOR TO BEING REIMBURSED FROM THE BOILERMAKERS LOCAL 83 SUPPLEMENTAL HEALTH & WELFARE FUND PLAN

INSTRUCTIONS FOR SUBMITTING CLAIM FORM:

Use this form to request reimbursement of the covered insurance premiums you have incurred on behalf of yourself, your spouse, and/or your eligible dependents. Covered insurance premiums submitted for reimbursement must have been incurred after you became a participant eligible to file claims.

HOW TO FILE YOUR CLAIM:

1. If you have coverage through the Boilermakers National Health and Welfare Plan ***and*** have filled out your HIPAA authorization, the Boilermakers Local 83 Supplemental Health and Welfare Fund will get your premium information directly from the Health & Welfare Department.

2. Fully complete all requested information. Missing information may delay the processing of your claim and could result in your claim being denied. Do not forget to sign and date the form.

3. For covered insurance premium reimbursement, you must attach documentation which includes the following: (1) names of covered individuals; (2) premium amounts; (3) policy period; and (4) insurance provider name and address. This information is typically contained on your premium billing notice. NOTE: Premiums paid under a spouse's employer plan are eligible for reimbursement as long as you are a covered dependent under that policy.

4. For covered insurance premiums paid for coverage other than under the Boilermakers National Health and Welfare Plan must be accompanied by the following: (1) copies of your original bill; and (2) copies of your cancelled checks; or (3) A paid receipt or letter from your health insurance carrier verifying the amount of premium paid by you for the given time period (this letter must have an address and phone number of the health insurance carrier and the signature of an authorized representative of the company).

COVERED EXPENSES:

1. Premiums of self-payments paid for coverage under a health care plan.

2. Premiums paid to the spouse's employer for your dependent coverage under your spouse's health plan.

3. Medicare Part D prescription drug premiums.

4. COBRA premiums.

NON COVERED EXPENSES:

1. Self-payments or premiums paid for Medicare Parts A & B are not eligible for reimbursement.

2. Self-payments or premiums paid only for separate dental or vision coverage.

3. Self-payments or premiums paid only for dependents or surviving spouses.

4. Expenses incurred for medical treatment or services, such as amounts paid to doctors, hospitals or pharmacies.

5. Amounts paid to medical service providers for insurance deductibles, co-pays, etc.

6. Amounts paid to Health Savings Accounts (HSA) or Flexible Spending Accounts.