LOCAL 731, I.B. OF T. WELFARE FUNDS
HEALTH SPENDING ACCOUNT REIMBURSEMENT

NAME____ ID#______________________________
(Member's Information) (ID# from your health Insurance or drug card, or last four of your Social Security Number)

INSTRUCTIONS

Fill in the necessary information below for health expenses incurred by you, the member, or your eligible dependents for which you request reimbursement. EXPENSES MUST BE INCURRED ON OR AFTER JANUARY 1, 2020 or your effective date in the Plan, whichever is later. This is for out-of-pocket expenses NOT covered by insurance. Expenses must be submitted no later than 60 days from the year in which the expense was incurred. Medical expenses will be reimbursed automatically by the Fund office.

Please attach your Explanation of Benefits from Delta Dental, vision receipts, prescription receipts, etc. Receipts must show the patient's name, the date the expense was incurred and an explanation of what the expense was for. Questions, please visit www.ibt731funds.org, or call 630-887-4150.

Date Expense was Incurred	Name of Individual Incurring Expense	Your Out-of-Pocket Expense
		$
		$
		$
		$
		$
		$
	TOTAL:	**$**

I certify that I will not claim these expenses as an income tax deduction and that the expenses comply with the requirements of the Plan. I also certify that I am not receiving reimbursement for the above requested out-of-pocket expenses through any other fund or insurance plan.

______________________________________ ______________________________
Member Signature Date

Please return to: Local 731 I.B. of T. Health & Welfare Funds
1000 Burr Ridge Parkway, Suite 301
Burr Ridge, IL 60527

January 2021