



## BOILERMAKERS LOCAL 83 SUPPLEMENTAL HEALTH & WELFARE FUND

### Supplemental Health & Welfare Fund Claim Form January 1, 2009 through June 30, 2009

Name \_\_\_\_\_ SSN \_\_\_\_\_

Address \_\_\_\_\_

City, State Zip \_\_\_\_\_

This form will cover claims for the period **January 1, 2009 through June 30, 2009**. The form must be completed, signed and submitted to the Fund Office by **August 31, 2009** in order to receive benefits. Checks will be issued in **October 2009**.

CLAIMS PERIOD	AMOUNT OF PREMIUMS	NAMES OF COVERED INDIVIDUALS	PROVIDER(S)
<b>January 1, 2009 – June 30, 2009</b>			

If you have coverage through the Boilermakers National Health and Welfare Plan *and* have filled out you HIPAA authorization, the Boilermakers Local 83 Supplemental Health and Welfare Fund will get your premium information directly from the Health & Welfare Department. All other premiums being claimed must be accompanied by the following:

- Copies of your original bill **and**
  - Copies of your cancelled checks (copies must be front and back)
- OR**
- A paid receipt or letter from your health care provider 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 care provider and the signature of an authorized representative of the company)

**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**

\_\_\_\_\_  
**Date**

Managed for the Trustees by:  
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