



BOILERMAKERS LOCAL 83 SUPPLEMENTAL HEALTH & WELFARE FUND

Supplemental Health & Welfare Fund Claim Form July 1, 2011 through December 31, 2011

Name _____ SSN _____

Address _____

City, State Zip _____

This form will cover claims for the period **July 1, 2011 through December 31, 2011**. The form must be completed, signed and submitted to the Fund Office by **February 28, 2012** in order to receive benefits. Checks will be issued in **April 2012**.

CLAIMS PERIOD	AMOUNT OF PREMIUMS	NAMES OF COVERED INDIVIDUALS	PROVIDER(S)
July 1, 2011 – December 31, 2011			

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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