NCF
NORTHEAST CARPENTERS FUNDS

(716) 839-7132 • 1-877-739-7136 • www.nrccf.org
1159 Maryvale Drive, Suite 20, Cheektowaga, NY 14225

Application for Health Reimbursement Account Withdrawal
(Please complete below, sign at the bottom and return to the BUFFALO office)

_____ _____
Member's Name Social Security Number

_____ _____
Address City, State, Zip Local Number

_____ _____
Telephone Number $Amount Requested

NO FAXED or EMAILED COPIES WILL BE ACCEPTED

Check type of Non-taxable Benefits applied for: You May Choose More Than One Expense

_____**MEDICAL EXPENSES** _____**PRESCRIPTIONS**

_____**DENTAL EXPENSES** _____**OPTICAL EXPENSES**

_____ **ORTHO EXPENSES**
COPY OF CONTRACT ATTACHED (REQUIRED)

Submit **detailed bills and/or corresponding Explanation of Benefits from Insurance along with a receipt showing payment.** All detailed bills must show dates of service, name of patient, diagnosis and explanation of benefits from any other insurance carrier or plan. Expenses submitted may only be submitted for self, legal spouse, or dependents. **Claims must total a minimum of $100.00(except Jan or July) and you must have $2,000.00 or more in your Health Reimbursement Account.**

_____ **MEDICAL INSURANCE PREMIUM REIMBURSEMENT**

Submit pay stubs clearly showing deductions for medical premiums are after taxes. If it is not clearly stated on the paystub, a letter is required from the employer verifying they are **POST -TAX** health insurance benefits. The letter must include the medical premium cost to the employee, name of person check is issued to, check date and company name.

Timely filing for any claim is one year from the date services were incurred.

Member's Signature_____ **Date** _____