North Atlantic States Carpenters
Benefit Funds

**Buffalo Office**
1159 Maryvale Dr., Suite 20
Cheektowaga, NY 14225
Phone: (716) 839-7132
Toll Free: 1(877) 739-7136
Fax: (716) 839-7136
www.carpentersfund.org

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) .**

_____ **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** _____