

MEDICAL EXPENSE REIMBURSEMENT REQUEST FORM



Local Number: _____

Date: _____

Member's Name		
Home Address		
Home Telephone Number	Cell Number	
Is Other Coverage Available:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Family Coverage	Single Coverage	
COBRA Monthly Premium Cost:	\$	
CO-Pays	Medical \$	Prescriptions \$
Dependents	Name	Relationship

The Robert Lilja Members' Relief Fund will reimburse for necessary healthcare covered expenses (i.e., doctor visits, prescriptions, etc.) less all co-pays. It is the member's responsibility to negotiate the charges with the healthcare provider to accept as payment in full payment an amount no less than what the insurance would cover prior to submission for reimbursement. A notation of this attempt must be made on each bill that is submitted. The information that you provide will remain confidential but is needed to authorize reimbursement of the expense.

Signature of Member

Date

Approved:

Local Union Committee