

SOUTHERN TIER BUILDING TRADES BENEFIT PLAN
202 WEST FOURTH ST. • JAMESTOWN, NY 14701 • PHONE (716) 664-4391

INDIVIDUAL REIMBURSEMENT ACCOUNT CLAIM FORM

PARTICIPANT INFORMATION		
PARTICIPANTS NAME:	DATE OF BIRTH:	
HOME ADDRESS:	TELEPHONE NO.:	
SOCIAL SECURITY NO.:	MARRIED <input type="checkbox"/>	SINGLE <input type="checkbox"/>
PATIENTS NAME:	RELATIONSHIP:	DATE OF BIRTH:
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DESCRIPTION OF EXPENSES AND REIMBURSEMENT REQUEST			
DATE(S) OF SERVICE OR PURCHASE	DESCRIPTION OF SERVICE OR ITEM	PROVIDER	REIMBURSEMENT REQUEST AMOUNT

PLEASE ATTACH ORIGINAL BILL FOR EXPENSES TO BE REIMBURSED (ALSO SUBMIT EXPLANATION OF BENEFITS IF SERVICES WERE CONSIDERED FOR PAYMENT UNDER ANOTHER MEDICAL PLAN).

TOTAL REQUEST FOR REIMBURSEMENT

(Total Must Be At Least \$100.00)

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT	
I certify that the above listed expenses for reimbursement from my Individual Reimbursement Account were incurred by me or an Eligible Dependent and are not covered, and will not be reimbursed by any other plan, policy, or program. I /we will not use the expenses reimbursed through the Individual Reimbursement Account as deductions or credits when filing my/our individual income tax return.	
ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY MISREPRESENTATION OR ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW AND MAY BE SUBJECT TO CIVIL PENALTIES.	
PARTICIPANTS SIGNATURE:	DATE: