

**EMPIRE STATE CARPENTERS WELFARE FUND**  
181 Industrial Park Road  
Horseheads, NY 14845  
Phone: (607)739-1326 Fax: (607)739-1415  
TOLL FREE (866)727-0281

Application for Health Reimbursement Account Withdrawal  
(please complete the area below and sign at the bottom)

Member's Name	
Social Security Number	
Telephone Number	
Address	

**Check Type of Non-taxable Benefit Applied For:**

\_\_\_\_\_ **MEDICAL REIMBURSEMENT**

\_\_\_\_\_ **DENTAL EXPENSES**

\_\_\_\_\_ **OPTICAL EXPENSES**

Submit detailed bills or corresponding Explanations of Benefits from Insurance showing dates of service, name of patient, diagnosis and explanation of benefits from any other insurance carrier or plan. I certify that the expenses submitted are for myself, my legal spouse, or my dependents, and are not covered under any other policy. **Original Bills and Explanations of Benefits Only, NO PHOTOCOPIES WILL BE ACCEPTED. Claims must total \$100.**

\_\_\_\_\_ **INSURANCE PREMIUM REIMBURSEMENT**

Submit pay stubs showing deductions for medical premiums or a letter from the employer verifying the **taxed** health insurance benefits including the cost to the employee. All such documentation must include name, social security number or payroll number and company name. (Pre-taxed medical insurance benefits are not eligible for reimbursement from the Health Reimbursement Account.)

**Member's  
Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

Properly submitted paperwork will be processed within 30 days