SOUTHERN PAINTERS
WELFARE PLAN
5 HOT METAL ST., SUITE 200
PITTSBURGH, PA 15203

TOLL-FREE: 1-844-851-7293
FAX: 1-412-431-4067

MEDICAL REIMBURSEMENT FORM

MEMBER INFORMATION – Please provide all requested information.

Member Name (Last, First, MI)	Member Social Security No.
Street Address ☐ Check Here if this is a Change of Address	
City, State Zip Code	Home Telephone No. ( )

MEDICAL EXPENSES INCURRED BY YOU, YOUR SPOUSE, OR YOUR ELIGIBLE DEPENDENT CHILDREN:

Pease attach documentation.

Name Of Provider	Date of Service	Amount
1._____	_____	$_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____
5._____	_____	_____
6._____	_____	_____
Total Of Reimburse		$_____

AUTHORIZATION – Please read the paragraph below, then sign and date.

I hereby certify that the expenses listed above have not been reimbursed and are not reimbursable under any other insurance policy plan, program or under any federal or state law. I also certify that I have not taken the expense as a deduction for income tax purposes. I also certify that these expenses have been paid by myself and are not duplicates of previously submitted claims. **Limited to expenses incurred within 12 months from the date of service.**

Member Signature	Date

Reimbursement forms MUST be received in the Fund Office no later than the 10th of the month to have a check issued on the 15th of the month

YOU MUST MAIL THIS FORM ALONG WITH ITEMIZED RECEIPTS TO THE FUND OFFICE FOR REIMBURSEMENT

Si le interesa leer esta correspondencia en español por favor contacta la Oficina del Fondo.
Servicios para miembros en español a 1-844-851-7768