

SHOPMEN'S LOCAL 527 BENEFIT FUND
2945 BANKSVILLE ROAD
PITTSBURGH, PA 15216
(412) 341-6183
Toll Free # 1 (800) 858-7870

MEDICAL SAVINGS ACCOUNT (MSA) CLAIM FORM

INSTRUCTIONS:

1. Please print and include all information requested. A separate claim form must be filed for each family member.
2. Enter total amount of each claim in the appropriate sections.
3. Supporting documentation must accompany this request form. Supporting documentation may include one of the following:
 - * ORIGINAL Explanation of Benefit Statements from the Fund Office, Major Medical, or other Medical plans. (NOT ACCEPTABLE FOR DENTAL CLAIMS)
 - * Bills or Receipts from doctor, dentist, or other supplier for expenses not covered by your Medical or Dental plan. (CASH REGISTER RECEIPTS ARE NOT ACCEPTED)
4. Retain copies of supporting documentation for your records as those submitted cannot be returned.

NOTE: ANY ITEMS FOR WHICH YOU ARE REIMBURSED CANNOT BE CLAIMED AS DEDUCTIONS OR CREDITS FROM YOUR FEDERAL INCOME TAX RETURNS.

MEMBER'S NAME _____ SOCIAL SECURITY # _____
 ADDRESS _____ EMPLOYER _____
 MEMBER COVERED BY HEALTHAMERICA OR KEYSTONE? YES () NO ()
 MEMBER COVERED BY BLUE CROSS & BLUE SHIELD? YES () NO ()
 MEMBER COVERED BY COBRA? YES () NO ()
 SPOUSE'S EMPLOYER _____ INSURANCE? YES () NO ()
 PATIENT'S NAME _____ RELATIONSHIP _____ BIRTHDAY _____

HEALTH CARE EXPENSES (EXPENSES NOT COVERED OR NOT PAID BY YOUR INSURANCE OR ANY OTHER PLAN)

PROVIDER	TYPE OF SERVICE	DATE OF SERVICE	MSA AMT. CLAIMED	FUND USE ONLY
TOTAL				

I certify that either myself and/ or my eligible dependents have incurred the expenses for which reimbursement is claimed from the Medical Savings Account and I further declare that I have not and will not deduct these expenses on my individual Income Tax Returns. No assignment will be accepted. All payments will be made to the employee. EXPENSES INCURRED FOR AN ON THE JOB ACCIDENT (WORKMEN'S COMPENSATION) ARE NOT COVERED.

 Employee Signature Date Phone Number

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FUND OFFICE USE ONLY

Date Paid _____ Claim Number _____ Total \$ _____