International Union of Painters and Allied Trades

District Council No. 21
Welfare Fund
Health Care Reimbursement Account Claim Form

(Please Check One)

☐	**Active Member**
☐	**Retiree**

Please Mail or Fax to:
2980 Southampton-Byberry Road
Philadelphia, PA 19154

Tel: 215-934-5130
Fax: 215-934-5418

Employee's Name LAST FIRST MIDDLE	Employee's Social Security Number
Employee's Street Address	Dependent's Full Name (claimant) LAST FIRST MIDDLE
City, State, ZIP	Dependent's Social Security Number

Please attach detailed statement of services from provider and/or explanation of benefits from IBC.

Dates of Service FROM	TO	Provider's Name	Description of Reimbursement Request *(See reverse side for details)*	Requested Reimbursement Amount

International Union of Painters and Allied Trades District Council No. 21
Claim Certification

I certify that Reimbursement Claim expenses have been incurred and paid by me, my spouse, or dependent(s), and have not or will not be reimbursed from any other source and have not or will not be used by me, my spouse or my dependent(s) as deductions in filing income tax returns.

Signature _____ Date _____

(Please see reverse side of form)