IBEW LOCAL 400 SUPPLEMENTAL BENEFIT FUND
PO BOX 1028
WEST TRENTON NJ 08628

Application for Retiree Medical Reimbursement Benefits
or
Supplemental Health Benefits
(Please Print or Type)

Section I - Personal Information

Name of Applicant _____Social Security #_____

Street Address_____

City, State, Zip _____

Date of Birth _____/_____/_____ Telephone # ( ) _____

Section II –Benefit Requested *(check one)*

_____ Retiree Medical Reimbursement Benefits - payable if you qualify for coverage under the IBEW Local Union 400 Welfare Plan as a retired employee and you have made all required contributions to maintain coverage. You are eligible to be reimbursed for the required retiree monthly contributions under the IBEW Local Union 400 Welfare Plan, up to the balance in your account. Retiree Medical Reimbursement Benefits are not subject to tax.

I request reimbursement for the months of _____, _____ through _____, _____.

_____ Supplemental Health Benefits - payable if you have qualified under COBRA for continued coverage under the IBEW Local Union 400 Welfare Plan or to upgrade coverage from Tier II to Tier I. You are eligible to be reimbursed for the required monthly contributions for COBRA under the IBEW Local Union 400 Welfare Plan or the required annual payment to upgrade coverage from Tier II to Tier I, up to the balance in your account. Supplemental Health Benefits are not subject to tax.

I request reimbursement of COBRA payments for the months of _____, _____ through _____, _____.

I request direct reimbursement to the IBEW Local 400 Welfare Fund of COBRA payments for the months of _____, _____ through _____, _____.

_____ I request Tier I coverage Single $675.00___ Parent/Children $1012.50___ Family $1350.00__
_____ I request Tier II coverage Single $506.25___ Parent/Children $759.38___ Family $1012.50__

Section III - Signature

_____ _____
(Signature of Applicant) (Date)