

.IBEW LOCAL 400 SUPPLEMENTAL BENEFIT FUND

PO BOX 1028

WEST TRENTON NJ 08628

FAX 609-983-7580

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 reimbursement of my payment to upgrade my coverage from Tier II to Tier I coverage in the amount of \$ _____.

Section III - Signature

(Signature of Applicant)

(Date)