PLUMBERS LOCAL 24 HEALTH REIMBURSEMENT ARRANGEMENT
PO BOX 1028
WEST TRENTON NJ 08628
FAX 609-883-7580

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 are under age 65 and qualify for coverage under the Plumbers Local Union 24 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 Plumbers Local Union 24 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 Plumbers Local Union 24 Welfare Plan. You are eligible to be reimbursed for the required monthly contributions for COBRA under the Plumbers Local Union 24 Welfare Plan, 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 Plumbers Local 24 Welfare Fund of COBRA payments for the months of _____, _____ through _____, _____.

Section III - Signature

_____ _____
(Signature of Applicant) (Date)