BAC Local #3 NY Buffalo Chapter Benefit Funds

1175 William Street
Buffalo, NY 14206
Phone: (716) 842-1318 Fax: (716) 842-1347

HEALTH REIMBURSEMENT FORM

Name: _____

Address: _____

Social Security #: _____ - _____ - _____

Telephone #: ( ) _____ - _____

I am requesting reimbursement for (check all that apply):

- ☐ Paid medical receipts (copays, prescriptions etc.)
- ☐ Pre-tax health insurance premiums (taxable)
- ☐ Post-tax health insurance premiums

I, the undersigned, certify that the above information is correct and that the attached receipts are paid in full. I certify that the attached receipts represent payments for IRS qualified medical expenses for myself or my dependents, and are covered under the Bricklayers & Allied Craftworkers Local #3 NY Buffalo Chapter Health & Welfare Fund. I understand that any false information and/or falsified documents I provide may subject me to criminal or civil fraud charges and/or larceny. Penalties for fraud offenses may include imprisonment, fines, probation, and restitution.

Signed: _____ Date: _____

FOR OFFICE USE ONLY

CODE 1: _____

CODE 2: _____

CODE 15: _____

CODE 4920: _____