

Bricklayers & Allied Craftworkers Local #3 Rochester Chapter Health & Welfare Fund

33 Saginaw Drive
Rochester, NY 14623

Phone: (585) 385-1160 *** Email: claimsroc@baclocal3ny.com *** Fax: (585) 385-9119

BENEFIT APPLICATION

Name of Applicant _____

Address _____

Social Security No. _____

Benefit Paid For: Self _____ Spouse _____ Dependent Child _____

CERTIFICATION

I, the undersigned, do hereby certify that the bills for which I am herein making claim, are valid, medically related expenses not covered by the benefits provided by the original Plan of the Bricklayers & Allied Craftworkers Local #3 Rochester Chapter Health & Welfare Fund, and do further grant the Administrator of said Fund permission to pay such bill or bills from the individual reserve in my name in whole or in part in accordance with the amount of excess contained in said reserve which exceeds the six month premium reserve originally provided for.

Date: _____

Signature

Pick up Check ☐ (FRIDAY)

FOR OFFICE USE ONLY

Personal Account – Medical

Service	Code	Amount
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Funded Benefit – Dental – Optical – Hearing Aid - Medical

Service	Code	Amount
_____	_____	_____
_____	_____	_____

APPROVED BY: _____

DATE PAID: _____