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

1175 William Street
Buffalo, NY 14206
Phone: (716) 842-1318 * Email: claimsbuf@baclocal3ny.com*****

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 Buffalo 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 ☐

FOR OFFICE USE ONLY

Personal Account – Medical

Service	Code	Amount

Funded Benefit – Dental – Optical – Hearing Aid - Medical

Service	Code	Amount

APPROVED BY:_____ DATE PAID:_____