

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

33 Saginaw Drive  
Rochester, NY 14623

Phone: (585) 385-1160 \*\*\* Email: tbarry@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)

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**FOR OFFICE USE ONLY**

**Personal Account – Medical**

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

**Funded Benefit – Dental – Optical – Hearing Aid - Medical**

Service	Code	Amount
_____	_____	_____
_____	_____	_____

APPROVED BY: \_\_\_\_\_

DATE PAID: \_\_\_\_\_