Claim For Reimbursement

Change of address

Contractor _____ Name_____

SS# or Mo-Kan #_____

Home address_____

Phone Number_____

Un-reimbursed Medical Expense Claims

Date Expense Incurred	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Amount
		Total Medical Care Expense:		

READ CAREFULLY

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the Company Health Reimbursement Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts from the Plan which relate to such expense.

_____ _____

Participant's Signature **Date**

Fax or mail completed forms and copies of bills, receipts or invoices to:
Mo-Kan Sheet Metal Workers Welfare Fund
P.O. Box 300019
Kansas City, MO 64130-0019
Fax: 816-753-7252 Phone: 816-531-0334 Toll Free: 1-866-531-5488