I.R.S.A. HEATLH AND WELFARE
ANNUAL CO-PAY REIMBURSEMENT REQUEST

Member Name: _____

Member Title: _____

Address : _____

_____

Home Phone : _____

List all co-payments separately / Yearly total $350.00 maximum

| | | |
|---|---|---|
| 1._____ | 8._____ | 15._____ |
| 2._____ | 9._____ | 16._____ |
| 3._____ | 10._____ | 17._____ |
| 4._____ | 11._____ | 18._____ |
| 5._____ | 12._____ | 19._____ |
| 6._____ | 13._____ | 20._____ |
| 7._____ | 14._____ | 21._____ |

***Remember to attach copies of all corresponding receipts / paperwork for amounts listed***

***Submission of this request for reimbursement signifies that you have not received, nor will you seek payment for these amounts from any other plan or provider***

Member Signature:_____ Date:_____

Mail form with receipt copies to: IRSA Health & Welfare Fund
P.O. Box 785
Babylon, N.Y. 11702-0785