

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

Member Name:			it.
Member Title:			
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		otal \$350.00 maximum	
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Remember to atta isted	ach copies of all corre	esponding receipts / paperv	vork for amounts
Submission of th nor will you seek pay	is request for reimbur ment for these amou	sement signifies that you hat from any other plan or	nave not received provider
Member Signature:_		Date:	
Mail form with recei		lealth & Welfare Fund	

P.O. Box 785 Babylon, N.Y. 11702-0785