FORM "A" **MEDICAL AND DENTAL RECORD** FORM "A"

HEALTH REIMBURSEMENT ACCOUNT PLAN OF THE ELECTRICAL INDUSTRY
158-11 HARRY VAN ARSDALE JR. AVENUE, FLUSHING, NY 11365

INSTRUCTIONS: *Please read carefully:*
List your MEDICAL AND/OR DENTAL BILLS ONLY ON THIS FORM
List bills in date order. Bills will not be accepted unless properly listed on this form. This form will not be accepted unless accompanied by original bills or an Explanation of Benefits voucher. Do not send in duplicate bills or bills previously submitted and paid through any other employee benefit plan. Return application, this form and bills, or an Explanation of Benefits voucher in the enclosed self-addressed envelope. SIGN THIS FORM at the bottom.

Date of Service	Provider's Name	Patient's Name	Relationship of Patient (Self, Spouse, Child)	Amount to be Reimbursed
				$

Total Amount to be Reimbursed $ _____

NOTICE

Any intentional statement of incomplete and/or incorrect information may result in disciplinary action including the institution of a civil and/or criminal proceeding. I have read the foregoing Notice and I certify to the completeness and accuracy of this application.

_____
Print Participant's Name

_____ _____ _____
Participant's Signature Social Security Number Date