Tile Layers Union Local 7 Welfare Fund
Supplemental Benefits
253 West 35th Street, 12th Floor
New York, N.Y. 10001
(212) 505 – 5050

Application for Supplemental Medical Benefit

Reimbursement for any necessary medical expenses not reimbursed by Local 7 Insurance and Welfare Fund. (Minimum $250.00)

Eligibility: Member MUST have an initial account balance of $2,000, and MUST maintain an ongoing balance of at least $1,000, in the Tile Layers Local 7 Welfare Fund Supplemental Benefit Plan.

Name: ______________________________ **Local No.** __________

Address: ____
(Street No.) (Street Name) (City) (State) (Zip)

Social Security No. _____-_____-_____ **Telephone No.** (____)_____-_____

If claim for eligible dependent:

Name: ______________________ **Age:** _____ **Relationship:** __________

Reason for Claim: ____________________________________
____
____

Amount Requested: $ ____________________

Attach all itemized bills, where applicable, substantiating above request.

Date ____/____/____ **Your Signature:** ____________________

I hereby authorize any hospital, physician, dentist, or any other qualified provider of covered services who has attended, examined or rendered services to me or an eligible dependent; or any business firm or other person that has had business dealings with me or an eligible dependent to disclose when requested to do so by the Board of Trustees or at their direction, any and all pertinent information in connection with this claim.

I swear that foregoing statements and enclosed documents, where applicable, are true and accurate to the best of my knowledge, knowing that the Board of Trustees will rely on same in consideration of this claim.

Signed: ____________________________