

IBEW LOCAL NO. 150 WELFARE FUND

31290 N. U.S. Highway 45, Unit B
Libertyville, IL 60048
(847)680-0032

PARTICIPANT'S NAME _____

(Please print)

PARTICIPANT'S SOCIAL SECURITY # _____ PHONE # _____

PARTICIPANT'S ADDRESS _____

MARK THE BOX IF THIS IS A CHANGE OF ADDRESS

REIMBURSEMENT REQUEST	
For each medical, dental, or vision reimbursement request, you must submit an Explanation of Benefits (EOB) form. For prescription drug reimbursement requests, you must submit a receipt or printout from the provider. If there is not enough in your account to cover the full amount requested, we will issue a check for your entire balance.	AMOUNT
Amount from EOB's	\$
Amount from prescription receipts	\$
Other	\$
TOTAL	\$

SEVERANCE PAYMENT REQUEST

Last day worked in covered employment _____

I hereby certify that the expenses for which I am requesting reimbursement have been paid in full.

PARTICIPANT'S SIGNATURE _____ **DATE** _____