RETIREE FLEXIBLE BENEFIT ACCOUNT REIMBURSEMENT REQUEST FORM

Return Completed Form to:
Michigan State Painters Insurance Fund
Flexible Benefit Account
6525 Centurion Drive
Lansing, MI 48917

Participant's Name _____ **Member ID or SS#** _____

Home Address _____
Street **City** **State** **Zip Code**

Telephone Number _____ **Date of Birth** _____

Email Address _____

Enclosed claims are for (check only one) ☐ **Self** ☐ **Spouse** ☐ **Son** ☐ **Daughter**

Dependent's Name _____ **Date of Birth** _____

Is dependent covered by another health insurance plan? ☐ **Yes** ☐ **No**

When Filing Claims

1. **Supporting documentation must accompany this Request Form. Supporting documentation includes any of the following:**

   - **Explanation of Benefit Form(s) indicating deductible, co-insurance and any amounts not paid from any Medical, Dental or Vision Plans under which you and/or any of your eligible dependents are covered.**

   - **Itemized bills from doctor, dentist or other supplier for recognized medical expenses not covered by your Medical/Dental/Vision Plans.**

2. **Retain copies of supporting documentation for your records, as those submitted will not be returned.**

3. **Send completed Reimbursement Request Form and supporting documentation to the Fund Office at the address above.**

I certify that either I and/or my eligible dependents have incurred the expenses for which reimbursement is claimed from the Flexible Benefit Account.

_____ _____
Employee's Signature **Date**