Northern California Plasterers Trust Funds

Health and Welfare Trust Fund, Pension Plan, and Plasterers Supplemental Pension Trust
4160 Dublin Blvd, Suite 100, Dublin CA 94568
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POINTS ACCOUNT: PREMIUM PAYMENT/ REIMBURSEMENT REQUEST

POINTS ACCOUNT BALANCES MAY BE USED TO PAY FOR THE COST OF COVERAGE UNDER THE PLAN, INCLUDING RETIREE PREMIUMS, SELF-PAY OR COBRA COVERAGE. POINTS ACCOUNT BALANCES MAY ALSO BE USED TO PAY FOR QUALIFIED MEDICAL EXPENSES, AS DEFINED UNDER §213d OF THE INTERNAL REVENUE CODE THAT ARE NOT COVERED UNDER ANY OTHER PLAN.

PARTICIPANT INFORMATION

LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER

MAILING ADDRESS (STREET OR P.O. BOX)	SEX	DATE OF BIRTH

CITY	STATE/ZIP	TELEPHONE NUMBER	EMAIL ADDRESS
		( )	

If you wish to apply your Points Account balance toward your cost of coverage, please check the appropriate boxes below.

☐ I wish to apply my Points Account balance toward the cost of my coverage. I am (check the applicable box below):

- ☐ A retired participant who is making a retiree self-payment.
- ☐ A disabled participant who is paying for COBRA.
- ☐ A surviving dependent of a deceased participant who is paying for COBRA.
- ☐ An active participant who is paying for Self-Pay or COBRA coverage. I understand that the Self-Pay or COBRA payment will be paid from my Points Account automatically each month. ***I also understand that if I return to work, it is my responsibility to notify Allied Administrators to stop these payments***.

If you wish to be reimbursed from your Points Account for qualified medical expenses, complete the following information:

PATIENT'S NAME	RELATIONSHIP TO PARTICIPANT

The minimum reimbursement amount is $300. List the qualified expenses not covered by any health plan. Attach an Explanation of Benefits (EOB), a receipt, or other evidence for each expense listed.

DATE(S) INCURRED	TYPE OF EXPENSE	AMOUNT

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT. I CERTIFY THAT I HAVE NOT PREVIOUSLY RECEIVED NOR WILL SEEK REIMBURSEMENT FOR THESE EXPENSES FROM ANY OTHER PLAN, AND I KNOW OF NO FACT THAT MAKES ME QUESTION WHETHER THIS EXPENSE IS PROPERLY REIMBURSEABLE UNDER THE PLAN.

Employee Signature _____ Date

INTERNAL OFFICE USE ONLY

☐ Approved Amount $_____ Date Paid _____

☐ Denied Reason for Denial:

REV 0117