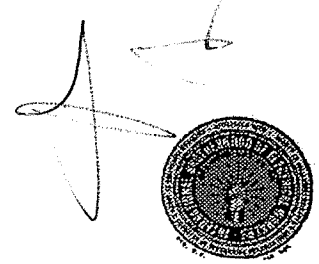




Michigan Electrical Employees' Health Plan
 6011 W. St. Joseph • Suite 401 • Lansing, MI 48917
 (517) 323-9250 • FAX #5173231093
 800-323-8943 (Michigan only)



SPECIAL FUND PAYMENT REQUEST FORM

DATE _____
 NAME _____ MEMBER'S SS # _____
 ADDRESS _____ LOCAL UNION # _____
 _____ PHONE # _____
 IS THIS A CHANGE OF ADDRESS? _____ YES

REQUEST FOR SELF-PAYMENTS*	OFFICE USE ONLY
SELF-PAYMENT \$ _____ (3-Month Period _____) RETIREE PAYMT - MONTH _____ AMT _____ WIDOW/SPOUSE PAYMT - MONTH _____ AMT _____ COBRA PAYMENT - MONTH _____ AMT _____	Code: _____ <u>SP035 - SP100</u> Month _____ Amount \$ _____ Hours _____ Fund 2 Hours _____ Approved _____

***PARTIAL PAYMENTS CANNOT BE MADE. IF YOU DO NOT HAVE ENOUGH IN YOUR ACCOUNT TO MAKE A SELF-PAYMENT, YOU WILL BE NOTIFIED BY RETURN MAIL. YOU WILL THEN HAVE TO REMIT THE PAYMENT. THE DUE DATE WILL NOT BE EXTENDED.**

REQUEST FOR MISCELLANEOUS EXPENSES	OFFICE USE ONLY	
MEDICAL EXPENSES \$ _____ DENTAL EXPENSES \$ _____ VISION EXPENSES \$ _____ OTHER EXPENSES \$ _____ TOTAL \$ _____	CODE _____ DOS _____ AMT _____ _____ HR	CODE _____ DOS _____ AMT _____ _____ HR
	CODE _____ DOS _____ AMT _____ _____ HR	CODE _____ DOS _____ AMT _____ _____ HR

YOU MUST ENCLOSE A COPY OF THE ITEMIZED BILL OR EXPLANATION OF BENEFITS (EOB) FROM BLUE CROSS/BLUE SHIELD. (INSTRUCTIONS AND COVERED EXPENSES ARE LISTED ON THE REVERSE SIDE)

By signing this request form, you certify that you have not taken and will not take a tax deduction for items submitted for reimbursement and that there is no other source available for payment.

SIGNATURE _____

PLEASE SUBMIT THE ORIGINAL FORM TO THE PLAN OFFICE.
 THE OTHER COPY MAY BE MAINTAINED FOR YOUR RECORDS.