Equity-League Pension, Health and 401(k) Funds
165 West 46th Street, Suite 812
New York, NY 10036

EQUITY-LEAGUE HEALTH FUND QCIP CLAIM FORM (11/13)

Your Name_____

The Address To Which You Want Your Payment Sent_____

Your AEA Member Number _____

Date Service Was Rendered_____

The Amount You Paid_____

Provider Name_____

Provider Address_____

Nature of the Service _____

If you are submitting a claim for medical expense you must submit a detailed billing statement from the provider including the name, address, telephone number and tax identification number of the provider and nature of the medical services rendered. You must also complete the certification below
I HEREBY CERTIFY THAT EXPENSES CLAIMED HAVE NOT BEEN REIMBURSED AND ARE NOT REIMBURSEABLE UNDER ANY OTHER HEALTH PLAN COVERAGE.

_____
SIGNED (Participant)

_____
Date

If you are seeking reimbursement of a health insurance premium (other than coverage through the Equity-League Health Fund) you must also complete this section:

The Medical Reimbursement program reimburses premiums for other group health insurance plans (i.e., sponsored by you or your spouse's employer or union) and for Medicare that cover you or your dependents. Only premiums made on a post-tax basis are eligible for reimbursement. The medical insurance policy or plan must provide you (and if applicable your dependents) with coverage for medical services such as hospitalization, surgery, x-rays, prescription drugs, etc. Premiums for other types of insurance (such as life insurance, accidental death and dismemberment insurance, loss of income insurance or automobile insurance) are not covered.

You must attach proof of payment of the premium and verification that it is group medical coverage provided (i.e. a premium billing statement and a canceled check and, a copy of the Summary of Benefits and Coverage or other summary of the coverage)

I HEREBY FURTHER CERTIFY THAT THE PREMIUM FOR WHICH I AM SEEKING REIMBURSEMENT WAS PAID PRE-TAX AND IS NOT AN INDIVIDUAL POLICY.

_____
SIGNED (Participant)

_____
Date