Operating Engineers Local 66 MRB Form

PO Box 38682, Pittsburgh PA 15238

PLEASE COMPLETE THIS FORM FOR REIMBURSEMENT

1. Member

Print Name

Social or last 4

Member Signature, I hereby request that the attached claims be considered for reimbursement from my Reserve of Contributions Account.

2. Member Reimbursement Benefit (MRB)

CHOOSE ONLY ONE

☐ Reimburse based upon the allowable amount of the claims attached/submitted.

☐ Reimburse this specific allowable amount from my Reserve based upon the claims submitted. I understand that if I select this option I will not be able to submit this/these claim(s) again to recieve any unpaid balance.

ENTER AMOUNT .

* If both or neither are selected, reimbursement will be based upon the allowable amount of the claims attached/submitted.

3. Requirements - Important, review this section before submitting a claim.

For a claim to be eligible for reimbursement it must meet the guidelines set forth in the Welfare Fundís Summary Plan Description (blue book). Please review the section titled Member Reimbursement Benefit. Below is a quick reference to apply for benefits, however it does not supercede the rules of the Summary Plan Description.

∑A Reserve account balance greater than twice the cost of Plan One, as of 2021 $7686.
∑ Member or dependent must be eligible for benefits.
∑ Claim(s) cannot be older than 36 months.
∑The base medical, prescription, or vision plans must be billed first.
∑ Reimbursement is based upon the Reserve balance on the date the claim is processed.
∑ No reimbursement is allowed for prescription drug co-payments.
∑ No reimbursement is allowed for medical deductibles or co-insurance.
∑ Submit only PAID itemized receipt(s).