MIDWEST OPERATING ENGINEERS
FRINGE BENEFIT FUNDS

PENSION TRUST FUND • WELFARE FUND • RETIREE WELFARE PLAN
VACATION SAVINGS PLAN • RETIREMENT ENHANCEMENT FUND

6150 JOLIET ROAD, COUNTRYSIDE, IL 60525-3994 - PHONE (708) 482-7300
CLAIMS FAX (708) 482-7687 - ELIGIBILITY FAX (708) 352-3310 - PENSION FAX (708) 354-7732

JAMES M. SWEENEY, CHAIRMAN / DAVID M. SNELTEN, SECRETARY-TREASURER

RETIREE MEDICAL SAVINGS PLAN (RMSP) ACCOUNT APPLICATION/AUTHORIZATION FORM

Member/Beneficiary Name: _____Medical ID#: _____

Address: _____Date of Birth: _____

PLEASE NOTE:

- **Your claim must be received by the Fund office no later than one year from the date of service.**
- Claims for RMSP reimbursement are limited to eligible members and their eligible dependents.
- If you are **NOT** covered under the MOE Retiree Welfare Plan, we will need a letter of pension approval on company letterhead showing you are in a retiree status with an effective date.
- For Deductible or Co-Pay reimbursement from another group health plan you must attach an itemized **PAID IN FULL** receipt from the doctor, dentist or supplier which identifies the person receiving the service and the date of service. A copy of the primary Explanation of Benefits should be sent when available.
- If your Medicare premiums are deducted from your Social Security check, we will need a copy of your monthly deposit statement. If your Medicare premiums should change, we will need a copy of your Social Security Award letter each year.
- Keep copies of your receipts or benefit statements for your records. Those you submit with your claim will not be returned.
- If you are a named beneficiary of the RMSP benefit, you may also use this claim form.

Enclosed please find documents for reimbursement related to: (**PLEASE CHECK ALL THAT APPLY**):

- ☐ Premiums for another healthcare plan.
- ☐ Expenses not payable under another plan including deductibles and co-pays (including Rx)
- ☐ Medicare Part A & B premiums
- ☐ Medicare Advantage Plan premiums
- ☐ Medicare Part D (prescription drug) plan premiums
- ☐ Medicare supplement premiums (“Medigap”)
- ☐ Tax-Qualified long-term care insurance premiums
- ☐ Tax-Qualified nursing care expenses
- ☐ Tax-Qualified home health care and hospice care expenses

I authorize the Administrative Manager of the Welfare Fund to use my RMSP account to reimburse me for the Supplemental Medical Benefits listed above. I understand that if the bill I am submitting exceeds the balance in my RMSP account that I will only receive reimbursement for the amount that is left in my RMSP account. I certify that either I and/or my eligible dependents have incurred the expenses and received the services for which reimbursement is claimed for the RMSP benefit. The expenses submitted for reimbursement are the actual fees I/we have been charged. I declare that I have not and will not deduct these expenses on my individual Income Tax return.

No assignment will be accepted. All payments will be made to the member/beneficiary at the address on file.

_____ _____

Member/Beneficiary Signature Date