MICHAEL J. DAY (MACHINISTS) RETIREE HEALTH INVESTMENT PLAN
4160 Dublin Boulevard, #400
Dublin, CA 94568
Phone: 925-833-7300 Fax: 925-588-7121

REIMBURSEMENT CLAIM FORM

Member's Full Name: **Last** **First** **Middle Initial**	**Social Security No.**
Home Address: **Number & Street** **City** **State & Zip**	
Home Phone Number ( ) **Work Phone Number( )**	
Employer:	**Union Local**
Name of Claimant: **Last** **First** **Middle Initial**	**Social Security No.**
Relationship to Member:	
Amount of Claim for Reimbursement:	**$**

Instructions:

1. Please attach copies of supporting documents showing your out-of-pocket expenses incurred for medical, dental, orthodontia and prescription drugs with regard to yourself, your spouse and dependents.

2. Retain copies of supporting documents for your records, as submitted materials will not be returned.

3. The supporting documents must show (1) the insurance carrier and/or health provider's name, (2) billing address of the carrier or provider, (3) premium amount billed to and/or paid by you, and (4) type of coverage provided (e.g., medical, dental, vision).

Please read, sign and date

I certify that either I and/or my eligible spouse/dependents have incurred the submitted expenses for which reimbursement is claimed from the Michael J. Day Machinists Retiree Investment Plan and I further declare that I have not and will not deduct these expenses on my individual tax returns. No assignments will be accepted - reimbursement will be made directly to me and I will pay (and/or have already paid) the carrier/provider directly.

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Member's Signature Date