Middletown Works Hourly & Salaried
Union Retirees Health Care Fund
1201 Crawford Street • Middletown, OH 45044
PH: (513) 217-4818 • TOLL FREE: (877) 392-9991 • Fax: (513) 672-9622

MEMBER BENEFIT REIMBURSEMENT CLAIM FORM

1. Complete a separate form for each type of benefit, and for each person.
2. Sign form and include receipt(s) and other supporting documentation.
3. Return to Fund Administrative Office via one of these methods:
    a) Mail or fax form and receipts to address/fax number shown above.
    b) Submit form and receipts via email to: mwrmemberservices@wpas-inc.com.

If you have any questions or concerns, please call **1-877-392-9991.**

Participant Information: Please Print

Name:_____ Relationship to Retiree:_____ Date of Birth:_____

Member ID #_____ Phone Number:_____

Mailing Address:_____

BENEFIT TYPE: Check one

☐ **Fitness Center** Must be submitted or postmarked by March 31 for previous year. $160/person/year max.	☐ **Implantable Ocular (Cataract) Lens** Lens only.	☐ **Hearing Aid** $4,000 per person every 3 years toward hearing aid devices only.
☐ **No Place Like Home** $750 individual, $1,000 family. Requires Occupational Therapy Home Assessment Report.	☐ **Transportation to Medical Appt.** Taxi or other licensed private carrier, up to $25/round trip. Limit $50/month.	☐ **Other** • Rx Co-pay • Covid-19 At-Home Test • Other

Name of Provider/Supplier/or Fitness Center	**Date of Service or Membership Year**	**Amount to Be Reimbursed**

Description of Services

IMPORTANT: YOUR SIGNATURE IS REQUIRED

I certify that I have paid the fees listed herein and that all information entered on this form is true and correct.

_____

Signature of Plan Participant Date