



**POINTS ACCOUNT:  
PREMIUM PAYMENT/  
REIMBURSEMENT REQUEST  
PLASTERING INDUSTRY WELFARE FUND**  
P.O. Box 2500  
San Francisco, CA 94126  
(415) 986-6276

POINTS ACCOUNT BALANCES MAY BE USED TO PAY FOR THE COST OF COVERAGE UNDER THE PLAN, INCLUDING RETIREE PREMIUMS, SELF-PAY OR COBRA COVERAGE. POINTS ACCOUNT BALANCES MAY ALSO BE USED TO PAY FOR QUALIFIED MEDICAL EXPENSES, AS DEFINED UNDER §213d OF THE INTERNAL REVENUE CODE THAT ARE NOT COVERED UNDER ANY OTHER PLAN.

**PARTICIPANT INFORMATION**

LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER
MAILING ADDRESS (STREET OR P.O. BOX)			SEX
			DATE OF BIRTH
CITY	STATE/ZIP	TELEPHONE NUMBER (     )	EMAIL ADDRESS

**If you wish to apply your Points Account balance toward your cost of coverage, please check the appropriate boxes below.**

- I wish to apply my Points Account balance toward the cost of my coverage. I am (check the applicable box below):
- A retired participant who is making a retiree self-payment.
  - A disabled participant who is paying for COBRA.
  - A surviving dependent of a deceased participant who is paying for COBRA.
  - An active participant who is paying for Self-Pay or COBRA coverage. I understand that the Self-Pay or COBRA payment will be paid from my Points Account automatically each month. *I also understand that if I return to work, it is my responsibility to notify Allied Administrators to stop these payments.*

**If you wish to be reimbursed from your Points Account for qualified medical expenses, complete the following information:**

PATIENT'S NAME	RELATIONSHIP TO PARTICIPANT
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*The minimum reimbursement amount is \$300. List the qualified expenses not covered by any health plan. Attach an Explanation of Benefits (EOB), a receipt, or other evidence for each expense listed.*

DATE(S) INCURRED	TYPE OF EXPENSE	AMOUNT

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT. I CERTIFY THAT I HAVE NOT PREVIOUSLY RECEIVED NOR WILL SEEK REIMBURSEMENT FOR THESE EXPENSES FROM ANY OTHER PLAN, AND I KNOW OF NO FACT THAT MAKES ME QUESTION WHETHER THIS EXPENSE IS PROPERLY REIMBURSEABLE UNDER THE PLAN.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

INTERNAL OFFICE USE ONLY		
<input type="checkbox"/> Approved	Amount \$ _____	Date Paid _____
<input type="checkbox"/> Denied	Reason for Denial: _____	