

# Supplemental Medical Premium Payment Form

Complete & return to Electrical Workers Local 86 Insurance Fund, 2300 East River Road, Rochester, NY 14623

## Member's Information

1. Member's Name (first, middle initial, last name) | 2. Member's Date of Birth | 3. Member's Social Security No.

## REQUEST FOR IBEW LOCAL 86 INSURANCE PREMIUM PAYMENT \*\*

Date bill is due \_\_\_\_\_

\_\_\_\_\_ Health Insurance Premium Amount Due

- \_\_\_\_\_ Amount in Supplemental Account to apply to current Bill \*\*\*

= \_\_\_\_\_ Amount still owed by member

In order to apply this Benefit from the Supplemental Medical Account, this form must be accompanied by  
A copy of **IBEW Local 86 Insurance Fund - Health Insurance Premium Notice**  
Payment of amount still owed by member, if any.

## OTHER INSURANCE PREMIUM REIMBURSEMENTS

(Applicable Only if #86 Insurance Cancelled)

Attach Premium Notice & Receipt of Payment

Date \_\_\_\_\_ Provider \_\_\_\_\_ Amount \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_ Received \_\_\_\_\_

**\*\* Self Payments are processed Monthly**

**There is no minimum balance requirement for payment of Health Insurance Premiums.**

**Payments will be applied only to the extent of the remaining available balance.**