

Supplemental Medical Transfer 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.
4. Member's Address		

Spouse's Information

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

AUTHORIZATION TO TRANSFER FROM SPOUSE'S IBEW LOCAL 86 SUPPLEMENTAL MEDICAL ACCOUNT TO MEMBER'S IBEW LOCAL 86 SUPPLEMENTAL MEDICAL ACCOUNT

Date bill is due _____

_____ Member's original Health Insurance Premium Amount due

- _____ Amount applied Member's Supplemental Premium Payment Form

- _____ Amount in Spouse's Supplemental Account to apply to Member's bill ***

= _____ Amount still owed by member

*** Call the Funds Office to get current available Supplemental Balance and amount still owed by member.
Funds Office phone number 585-235-1515 extension 1 Insurance Department

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 and
the Member's Supplemental Medical Premium Payment Form**
Payment of amount still owed by member, if any.

Member _____ Date _____

Spouse _____ Date _____ Received _____