

THEATRICAL STAGE EMPLOYEES HEALTH & WELFARE TRUST
c/o The William C. Earhart Company, Inc.
P.O. Box 4148
Portland, Oregon 97208

FOR ADMIN USE ONLY

AVAILABLE BALANCE _____

AMOUNT PAID _____

DATE/CHECK # _____

MEDICAL REIMBURSEMENT CLAIM FORM

I hereby request reimbursement for the item(s) listed below and certify that these are qualified expenses as defined in the Summary Plan Description. A paid receipt is attached for each item.

DATE OF SERVICE	DESCRIPTION OF EXPENSE	AMOUNT

TOTAL AMOUNT REQUESTED

Name: _____ Social Security # _____

Address: _____

_____ Date: _____