

# Theatrical Stage Employees Health & Welfare Trust

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Administered by  
 Welfare & Pension Administration Service, Inc.

## MEDICAL and DENTAL EXPENSE REIMBURSEMENT PLAN 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.

PLEASE PRINT

EMPLOYEE INFORMATION						
EMPLOYEE NAME – First	Initial	Last	<input type="checkbox"/> M <input type="checkbox"/> F	WPAS ID # OR SOCIAL SECURITY #	EMPLOYEE BIRTHDATE Mo. Day Year	
HOME ADDRESS	STREET	CITY	STATE	ZIP	PHONE #	
*PATIENT'S NAME – First	Initial	Last	<input type="checkbox"/> M <input type="checkbox"/> F	PATIENT BIRTHDATE Mo. Day Year	RELATION TO EMPLOYEE <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> D.P.	

\*One claim form per patient.

CLAIM INFORMATION			
DATE OF SERVICE	LIST PROVIDER OF SERVICE	DESCRIPTION OF SERVICE	AMOUNT
<b>TOTAL AMOUNT REQUESTED</b>			

**PLEASE SIGN AND DATE HERE:** I certify that all information provided is correct and that the expense(s) submitted are for me or members of my family who are eligible dependents. The patient has incurred expenses and I authorize release of all information contained on this claim to Welfare & Pension Administration Service, Inc., the Plan Administrator. Any person who knowingly and with intent to defraud the Plan or other person files an application for benefits or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Patient  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 (or Member Signature if Patient is Minor)

The Plan provides reimbursement for expenses incurred by you and any eligible dependent you claim as a dependent on your Enrollment Form.

If claim is for a dependent, please sign below confirming that the dependent is listed as an eligible dependent on your Enrollment Form.

Member  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_