

**ARIZONA PIPE TRADES HEALTH & WELFARE FUND**  
**P O Box 21240, Denver, CO 80221**  
**Telephone-toll-free 877-429-7473**

**Dental and Vision Claim Reimbursement Request**

Please complete applicable spaces on this form, attach appropriate statements and send to the above address

Retiree/Dependent Spouse Name \_\_\_\_\_  
\_\_\_\_\_

Social Security Number \_\_\_\_\_

Home Address \_\_\_\_\_  
\_\_\_\_\_

Expenses for which I am claiming reimbursement:

Date of Service	Provider	Amount
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

(\$200.00 maximum per calendar year)

**Please also complete the following requirements:**

1. Attach a bill from a Dental or Vision provider clearly showing the description of the expense, dates of service and amount charged.
2. Sign the following statement:

**I am claiming reimbursement only for eligible Dental and/or Vision expenses incurred during this calendar year. I certify that these expenses have not been previously reimbursed under this or any other benefit plan and will not be claimed as an income tax deduction.**

Retiree's Signature: \_\_\_\_\_

Date: \_\_\_\_\_