# NCCCAP HEALTH AND WELFARE
# SUBMISSION CLAIM FORM 20_____

**Member Name**:_____ **Last four digits S.S.#**:_____

Total $ Amount of all attached Claim(s):_____

Name(s) of individual(s) for whom claim is being made (if other than self):_____

_____

**Claim is for (check all that apply):**

- ☐ self
- ☐ spouse
- ☐ dependent you claim on federal tax return
- ☐ Person you could have listed on your federal tax return if that person had not received $4150 or more gross income or had not filed a joint return

**Nature of Claim: (please check)**

- ☐ Medical/Dental/Vision/other Expenses
- ☐ Dependent Care Expense
- ☐ Post-tax Premium Health Insurance Expense

**Declaration:**

- ♦ This submission has not, and will not be reimbursed by another health insurance program.
- ♦ The claim is for the person(s) and reason(s) stated above.
- ♦ Attached are documents indicating the claims have been paid.

I have read the Trust Fund (Health and Welfare) Handbook and understand my responsibilities in reference to the items that qualify, the privacy sections, and the Claim Submission Form directions.

Signature:_____ Date: ____/____/_____