IBEW Local 400 Wellness Annual Health Physical Reimbursement Form

Name of Person Requesting Reimbursement: ____________________________________

Relationship to Local 400 Welfare Fund Employee Participant: Self ____ Spouse: _____

E-Mail Address: ____

Phone Number: ____

Mailing Address: ____

____

Last 4 Digits of Social Security Number: ________________________________

Date of Annual Health Physical: ____

Physician's Name: ____

Please e-mail Health Physical Reimbursement Form to:

wellness@ibew400wellness.com

Via Postal Mail:

830 Bear Tavern Road

West Trenton, NJ 08628

Attn: Local 400 Health Reimbursement

If you require assistance or have any questions, contact Raquel Guzman, Wellness Coordinator at 732.497.9990