IBEW Local 400 Wellness Annual Health Physical

Reimbursement Form

Name of Person Requesting Reimbursement: ________________________________

Relationship to Member: Self ____ Spouse: _____

E-Mail Address: ____

Phone Number: ____

Members Address: ____

____

Members 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