

**MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND
FLU SHOT REIMBURSEMENT FORM**

Member Name: _____, _____
Last First Social Security Number

Date of Birth: _____ Local Union Number: _____

Street Address City State Zip Code

Dependent Information:

Dependent Name: _____
Date of Birth Social Security Number

Dependent Name: _____
Date of Birth Social Security Number

Dependent Name: _____
Date of Birth Social Security Number

Dependent Name: _____
Date of Birth Social Security Number

Dependent Name: _____
Date of Birth Social Security Number

You must include an **ORIGINAL** dated receipt for each person to be reimbursed. The maximum amount of reimbursement is \$30.00 per person. Send the form to: **Massachusetts Laborers' Health and Welfare Fund, 14 New England Executive Park, Suite 200, Burlington, MA 01803-5201**

I hereby certify that each person for whom I am seeking reimbursement has actually received the flu shot. I understand that any misrepresentation is considered fraud.

Member's Signature

Date