BRICKLAYERS & ALLIED CRAFTWORKERS
LOCAL #2, ALBANY, NEW YORK, HEALTH BENEFIT FUND
300 CENTRE DRIVE
ALBANY, NY 12203
1-800-664-8314

EDUCATION BENEFIT FORM CLAIM FORM (WRA)

Member Name:___________________________________ SS#______________________

Address:____

Please take note of the following points regarding the Education Benefit:

- Tuition fees are approved for reimbursement if the member, spouse and/or dependent child attends a qualified 'Educational Organization' as a candidate for a degree or certificate. Reimbursement for tuition claims will be processed when the semester has been completed with proper documentation.
- You must show proof that all claims have been paid.
- You must complete the back of this form to receive a benefit.
- Each claim must be listed separately and if there is more than one claimant they must be listed separately. No claim will be processed if older than 5 years.
- Some examples of materials/supplies that can be reimbursed are: books (receipt must show that the book is related to a particular class or course), lab fees, computer expenses, printer, calculator, ect.

All Benefits from your Wage Replacement Account ("WRA") are subject to federal and state income tax. The Plan is required to withhold all applicable taxes and, in some cases, the benefit may be subject to FICA. If FICA (or other mandated taxes) is required, the employee's portion will be deducted from your benefit. You might be subject to tax even if the Fund Office does not withhold taxes from the benefit. Please check with your tax advisor with questions relating to this. In addition, you may receive a W-2 Form or 1099 from the Fund at the end of the year.

Please complete a W-4 form for the Education. If the Fund Office does not have a W-4 on file, we are required to withhold based on single/zero exemptions. You may change your W-4 election twice per year; in June for July and in December for January.

FOR OFFICE USE ONLY

Approved by ________	**Date** _________	**Amount Requested** _________
Reviewed by ________	**Date** _________	**Amount Approved** _________
Amount Paid ________	**Date** _________	**Amount Denied** _________

Student Name	School	Semester	Tuition Amount	Loan(s) Amount	Supplies / Materials		Total Amount Requested
1.					Merchant:		
					Item:		
					Amount:		
2.					Merchant:		
					Item:		
					Amount:		
3.					Merchant:		
					Item:		
					Amount:		
4.					Merchant:		
					Item:		
					Amount:		
5.					Merchant:		
					Item:		
					Amount:		
6.					Merchant:		
					Item:		
					Amount:		
7.					Merchant:		
					Item:		
					Amount:		

Please use additional sheets if necessary

GRAND TOTAL $_________________

I hereby certify that the above statements are complete and accurate to the best of my knowledge. I also agree to reimburse the Fund and/or the Administrator to the extent of an overpayment, which is in excess of the amounts payable under the plan. Further, I acknowledge the Fund has a processing fee regarding all benefits with the exception of the Supplemental Unemployment benefit. ANY PERSON WHO KNOWINGLY AND WITH THE INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY AGENCY OR ADMINISTRATOR FILES A STATEMENT OF CLAIMS CONTAINING ANY FALSE, INCOMPLETE INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNSHIABLE UNDER LAW.

Participant Signature: ____ DATE: ____________