

NORTHEASTERN NEW YORK DISTRICT COUNCIL
PIPEFITTERS WELFARE FUND

Local 773
30 Bluebird Road
P.O. Box 1343
So. Glens Falls, NY 12803

LAWRENCE J. GONNELLY
Fund Administrator

Phone: (518) 792-0586
Fax: (518) 792-0732

**CERTIFICATION AND HOLD HARMLESS AGREEMENT
FOR HEALTHCARE EXPENSE BENEFIT**

I, _____, hereby apply for Health Care Assistance Benefits from the Northeastern New York District Council Pipefitters Welfare Fund.

I certify that I have incurred health care expenses for ___ myself, ___ my spouse, ___ my dependent children; and that such health care expenses are not covered nor have they already been paid by the Welfare Fund's Insurance Benefit or by any other insurance program (including insurance coverage maintained by my spouse).

I request that payment for these expenses be made to me. **Copies of the paid bills are attached.**

I hereby agree to reimburse the Welfare Fund for any sums it pays in reliance on these certifications if they prove to be inaccurate or false, and to indemnify the Trustees of the Welfare Fund, and hold them harmless, against any costs, expenses or damages they may incur or suffer as a result of any such inaccuracy or falsity.

DATE: _____

(Name)

Social Security # _____

(Address)

Witness Signature (other than spouse or dependent)

Print Witness Name