Salaried Retirees of
Lone Star Industries, Inc.
Benefit Plan

Associated Administrators, LLC
P.O. Box 1062
Sparks, Maryland 21152-1062
Telephone: (866) 566-7827
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LONE STAR MEDICAL REIMBURSEMENT ACCOUNT (MRA)
CLAIM FORM

Member's Name: ____

Patient's Name (if different): ____

Member's SSN: ____

Address: _________________________ City: __________________ State: ______ Zip: _______

Member's Telephone Number: ____
(Include Area Code)

Unreimbursed Medical Expense Claims

Date Expense Incurred	Name of Service Provider	Expense Description	Net Amount

READ CAREFULLY:

The above is a true and accurate statement of unreimbursed medical expenses incurred by me on the date(s) indicated. These expenses were incurred while I was covered under then Lone Star Retirees Medical Reimbursement Account. I have submitted any medical expenses covered by other medical plan(s) to those plans, but payment has been denied in full or in part, as shown on the attached form. Receipts from my service provider(s) for all expenses are attached to this voucher.

Signature: ___________________________________ Date: ______________________________

Please send claims to:

Associated Administrators, LLC
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Sparks, MD 21152-1062