

HRA Request for Reimbursement of Qualified Expenses

Complete this form and send with supporting documentation to: Plumbers Local 6, c/o: Zenith Administrators, P.O. Box 26, Minneapolis, MN 55440-0026.

- Supporting documentation may consist of: Bills, Premium Notices, Explanation of Benefits, Receipts.
- A separate form must be completed for each eligible dependent.
- Each form of documentation must contain the date(s) of service, provider name, provider address, description of treatment, service or supply, as well as the name of the claimant.
- **PLEASE NOTE:** Do not submit claims for charges eligible for payment under your Insurance or Medicare. This includes all amounts available for reimbursement under Health FSAs unless you have exhausted the account balance. Do not submit claims after the later of twelve (12) months from when you received the medical service. Do not submit claims for services prior to your benefit eligibility date.

Participant Information

Plan Name: Plumbers and Steamfitters Local #6 HRA

Participant's Full Name: (Last, First, Middle Initial)		Mailing Address:	
		Street _____	
Participant Social Security Number		City _____	
_____ - _____ - _____		State _____ Zip Code _____	
		Is this address a change? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Gender	Marital Status	Date of Birth	
<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Married <input type="checkbox"/> Single	_____/_____/_____	
		(Month) (Day) (Year)	
Home Phone Number		Work Phone Number	
(_____) _____ - _____		(_____) _____ - _____	
Area Code		Area Code	

Claim is for: Self, Spouse, Dependent Child, Other Dependent, Non Spouse or Non Dependent Beneficiary.

Claimant's Full Name: (Last, First, Middle Initial)	Claimants Social Security Number:
	_____ - _____ - _____

Request for Reimbursement of Non-Recurring Expenses: (co-payments, medications, out of pocket expenses).

Summary of Healthcare Expenses:

Incurred Date*	Provider (Doctor, Pharmacy Name)	Description of Service	Amount to be Reimbursed

* Incurred date is the date the service was rendered, not the billing or payment date.

Read Carefully:

The undersigned certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred by the participant, the participants spouse, the participants eligible dependents, or a designated beneficiary (after the participants death only) while the undersigned was eligible to receive benefits under the HRA Plan. The undersigned certifies as follows:

1. The medical expenses have not been reimbursed and are not reimbursable under any other health plan, dental plan, or Medicare.
2. The undersigned acknowledges that all amounts available for reimbursement under Health FSAs have been exhausted.
3. Non prescription medications for which reimbursement is requested were purchased to alleviate or treat personal injuries or sickness.
4. The undersigned understands that she / he alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim.
5. The undersigned understands that she / he will be liable for payment of all related taxes including Federal, State, or local income tax on amounts paid from the plan for non-qualifying expenses.

Signature:	Date:
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