ADMINISTRATION OFFICE
4th DISTRICT IBEW HEALTH FUND
*9200 US Route 60 * Ona, WV 25545*
*Telephone: (304) 525-0331 * Fax: (304) 525-6005*
hra@abchldg.com

HRA REIMBURSEMENT REQUEST FORM

Complete the information below for qualifying medical expenses incurred by you, your spouse, or other qualified dependents, for which you request reimbursement payments. Examples of qualifying expenses can be found in the Summary Plan Description (SPD). Be sure to complete all information. Only enter the last four digits of your SSN, and include proof of the expense. Proof of the expense includes an itemized third-party receipt or an explanation of benefits (EOB). Date and sign the form and send the form along with all proof of expenses to the HRA department at the address listed above. We suggest you send copies of the proof of expenses as they will not be returned to you.

Member Name:_____ SSN:_____

Address:_____

Date of Service/ Date Purchase Made	Provider/ Merchant	Individual Receiving Service	Relationship	Type of Expense	Amount Requested for Reimbursement

Proof of Expense is required for reimbursement. All incomplete or undocumented request will be denied.

I attest that the information stated above is true and I have not been reimbursed previously under this Plan or another Plan, or expect these amounts to be reimbursed elsewhere. I understand that these expenses cannot also be claimed as a Federal Income Tax Deduction or cred on my Federal Income Tax Forms.

_____ _____

Employee Signature Date