IBEW9+MSECA
PARTNERS FOR PROGRESS

IBEW9+MSECA HRA Benefit Claim Form

18670 Graphics Dr, Ste 201 | Tinley Park IL 60477-6257

Questions? 866-661-1021

Participant's Name_____Telephone_____Last 4 of SSN_____

Address, City, State, Zip_____

Email_____ HRA Plan (choose one): _____Retirees ____Actives

List claims for which you are attaching itemized receipts. If you are responding to a letter requesting a receipt, you may send the letter instead of completing this form.

Wait! Save postage and paper! Upload an image of your receipt using the HRA desktop or smartphone app. Download the free IBEW9 HRA app from Google Play or the Apple App Store, or use the desktop app at https://ibew9mseca.lh1ondemand.com. **You can even create a brand new claim for items not paid with the HRA VISA**. If you've not set up your online account yet, your first-time login ID is your first initial, last name, plus the last for digits of your SSN (example, jsmith1234), and your password will be your date of birth plus the last four digits of your SSN (example, January 1, 1961 would be 0101611234).

Date Incurred	Covered Participant Name	Service Provider or Vendor	Expense Description	Expense Amount
				$
				$
				$
				$
				$
				$
				$
				$
			Total	$

If you paid for your claims with your HRA VISA card, you do not need to complete the rest of this form. If you are requesting reimbursement for claims not paid with your HRA VISA, please finish filling out the form.

Participant Authorization By signing below, I certify that all services for which reimbursement is requested on this form were provided while I was eligible for coverage under the Plan and were for me personally. Further, I certify that the eligible expenses have not been otherwise reimbursed, nor will they otherwise be reimbursed, through any other source; that they have not been paid or are not eligible for payment on a pre-tax basis; and that they have not been taken, nor intend to be taken, as a tax deduction. I understand that the Internal Revenue Code permits reimbursement only for eligible health care expenses. I understand that I alone am fully responsible for the sufficiency, accuracy, and truthfulness of all information relating to the claims on this form and that I am liable for payment of expenses and that if an expense is not eligible for reimbursement under the Plan's HRA benefit, I am liable for payment of all related taxes on amounts paid by the Plan that relate to these expenses.

Participant's Signature_____Date_____

☐ I choose Direct Deposit reimbursement

Processed weekly, no minimum

☐ **Bank info previously submitted (you don't need to complete the banking info again)**

Name on Account	Bank Name
Bank Routing Number	Bank Account Number
Type of Account (circle one) Checking Savings	☐ I authorize the Plan to use this account for all HRA reimbursements until I advise the Plan otherwise.
Authorized Accountholder Signature	Date

☐ I choose Paper Check reimbursement

and I understand that by doing so my cumulative claims must equal or exceed $50 before a reimbursement payment will be issued to me, and that reimbursement checks are processed only once a month.

Claim and Reimbursement Procedures

To receive reimbursement for eligible expenses, or to substantiate claims for expenses you paid with your HRA VISA, you may submit this written claim form with the required supporting documentation instead of submitting the claim via the Participant Portal, using the procedures described here. Reimbursement is paid directly to you; you are responsible for paying any providers.

While you can submit requests for reimbursement at any time, **the Plan requires that if you are requesting a paper check your cumulative requests for reimbursement must total $50 or more before a check will be issued, and that paper checks are issued only once a month.** The amount reimbursed for any eligible expenses will not exceed your HRA Account balance at the time reimbursement is requested. However, in the event your available balance is less than $50, you may submit eligible expenses totaling less than $50 to close out your HRA Account. You must file a claim for reimbursement with the Plan within 12 months of the date of the expense or your claim may not be accepted and may be denied.

Along with this form, you must provide any of the following, as applicable:

- An itemized bill or receipt from the service provider that includes the name of the person incurring the charges (it must be you), date of service, description of services, name of provider, and amount of charge.
- An original Explanation of Benefits (EOB) from any coverage (including any EOB from this Plan) when requesting reimbursement of the balance of charges for which coverage is available plus original receipts verifying payment.
- Proof of the amount and date paid when requesting reimbursement for other insurance premiums, such as a spouse's group health coverage premiums and verification that the premium was not paid or eligible for payment under an IRC Section 125 Plan. Additional documentation is also required for reimbursement of premiums.
- An original, itemized receipt and proof of purchase or rental for covered items (such as for crutches or wheelchairs).
- Any additional documentation requested by the Plan.

If you are eligible for other coverage, you must include a copy of the Explanation of Benefits (EOB) from the other coverage. Only eligible expenses that have not already been reimbursed, as shown on the EOB form, will be eligible for reimbursement.

If you submit an EOB, you do not have to submit an itemized receipt.

It's a good idea to make a copy of everything you submit for your records, because materials you submit will not be returned to you.