# Local No. 9, IBEW and Outside Contractors Health and Welfare Fund

# Health Reimbursement Arrangement (HRA) Account Claim for Reimbursement

## Participant Information:

Participant's Name_____Telephone_____BCBS ID No._____

Address, City, State, Zip_____

**Attach appropriate receipt(s) for each expense listed below when submitting form;** please see the reverse side of this form for more details on what to provide. **Requests for reimbursement must total a minimum of $50 unless the claim filing time limit applies.**

| Date Expense Incurred | Service Provider | Expense Description | Person for Whom Expense Incurred | Expense Amount |
|---|---|---|---|---|
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| ***Total*** | | | | $ |

**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 or my eligible dependents, as defined by the Plan. Further, I certify that the eligible expenses have not been otherwise reimbursed, nor will they otherwise be reimbursed, through any other source, have not been paid or are not eligible for payment on a pre-tax basis, and 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 Account, I am liable for payment of all related taxes on amounts paid by the Plan that relate to these expenses.

Participant's Signature_____Date_____

If you are not a Local 9 Pensioner from this office, you will need to send in a copy of your Pension or Social Security Award Letter with this completed claim form.

### Claim Submission

Mail completed form and any required documentation to:

IBEW9OC Health and Welfare Fund
One Westbrook Corporate Center, Suite 430
Westchester, IL 60154-5701

| Fund Office Use Only | |
|---|---|
| Participant's beginning balance | |
| Less approved charges, this claim | |
| Participants ending balance | |
| Processed by | |
| Paid date | |
| Check number | |
| Basys Refno | |

# Claim and Reimbursement Procedures

To receive reimbursement for eligible expenses, you must submit this written claim form, with the required supporting documentation, to the Plan in accordance with the Plan's claim procedures as briefly described here and in more detail in your Summary Plan Description. 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 any requests for reimbursement be for a minimum of $50.** Therefore, you will have to hold your requests for reimbursement until you have at least $50 in eligible expenses. In addition, the amount reimbursed for any eligible expense will not exceed your HRA Account balance at the time reimbursement is requested. However, in the event your Plan coverage ends, you may submit eligible expenses totaling less than $50 to close out your HRA Account. You must file a written 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 original itemized bill from the service provider that includes the name of the person incurring the charges, 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 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, your spouse, and/or your dependents are eligible for other coverage, you must include a copy of the Explanation of Benefits (EOB) from the other coverage as well as any EOB from this Plan. Only eligible expenses that have not been reimbursed, as shown on the EOB form, will be eligible for reimbursement.**

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