Plumbers & Steamfitters Local 33 Health & Welfare Fund

2501 Bell Avenue Des Moines, IA 50321-1118
Phone 515.243.3246 Fax 515.244.6606 www.ualocal33.org (View Fund Office Tab)

Health Reimbursement Account (HRA) Claim Form

Member Name: _____

Expense Information (please print)

Please complete the form below for each item you wish to have paid from your HRA. The following expenses can be reimbursed from your HRA:
• Major medical deductible • Major medical co-insurance • Dental & Hearing (expenses in excess of the annual benefit) • Vision (expenses in excess of the annual benefit up to $1,000 per person/per year) • COBRA premium payment • Retiree premium payment • Chiropractic care up to $1,000 per person/per year • Fitness club memberships (must have a prescription from your physician) • Orthodontia treatment $1,500 (one time per dependent under age 19)

The following expenses cannot be reimbursed from your HRA:
• Prescription co-pays • Items that are not covered by the Plan (i.e. LASIK surgery, charges over Usual & Customary, claims received after 1 year from date of service, etc.).

QUALIFIED HEALTH CARE EXPENSES					
Date Expenses Incurred (mm/dd/yy)	Name of Service Provider	Expense Description (i.e. COBRA payment, major medical deductible, etc.)	Patient	Pay Member or Provider (provide proof of payment if designating member)	Amount to Pay from HRA
Example 1/1/12	*Dr. Jones*	*2012 Major Medical Deductible*	*Brenda*	*Dr. Jones*	*$250.00*
Example 2/1/12	*N/A*	*Retiree Self Pay Premium Payments February - June, 2012*	*N/A*	*N/A*	*$4,175.00*
Total Reimbursement from HRA			(minimum reimbursement is $25.00)		**$**

Do you have other insurance that is secondary to this plan? Yes or No (circle one)

If the answer is yes, your claim must be filed with your secondary carrier before your HRA is processed. A copy of the secondary carrier's explanation of benefit (EOB) must be included with this submission for reimbursement.

This is to certify that my statements on this Claim Form are complete and true. I certify that any expenses reimbursed are for eligible medical expenses for myself, my spouse, or eligible dependents and such expenses have not and will not be reimbursed under any other Health Reimbursement Account, insurance plan, nor be claimed as an income tax deduction.

_____ _____

Member's Signature Date