Local Union No. 598 Plumbing & Pipefitting Industry Health & Welfare Plan & Trust

Health Reimbursement Arrangement (HRA) Claim Form

(Please see the reverse side for instructions in preparing and submitting this form)

Completed forms should be forward to:

Local Union No. 598 Plumbing & Pipefitting
PMB #116
5331 S Macadam Avenue, Suite 258
Portland, OR 97239

For questions regarding your account balance, the status of claim payments, eligible expenses or how to file a claim on-line, log onto the Local Union No. 598 Plumbing & Pipefitting website: www.ua598benefits.org or call the Trust office at: (800) 205-7002

PARTICIPANT Information (Please print legibly):

Name (Last, First, M.I.)	Social Security Number
Address (Street, City, State, Zip)	Daytime Telephone

Allowable Medical Care Expense Information Please complete all of the information for each expense listed below. You must also attach supporting documentation for each expense (for example, an itemized bill, Explanation of Benefits (EOB), or receipt). It is a good idea to make a copy of all materials you submit for your records.

NOTE: Cancelled Checks or credit card receipts/statements are not valid forms of documentation. The reimbursement form must be signed and dated as unsigned forms will not be processed.

**List each expense separately

Person for whom Expense was Incurred Relationship to Member	Date(s) Expense Incurred	Name of Service Provider	Expense Description	Reimbursement Amount Requested from HRA
				$
				$
				$
				$
				$
			Total Reimbursement from HRA :	$

☐ **Check here to sign up for monthly automatic reimbursement of premium payments**

Certification: PARTICIPANT MUST SIGN BELOW, UNLESS THERE IS WRITTEN AUTHORIZATION ON FILE WITH THE ADMINISTRATIVE OFFICE ALLOWING A SPOUSE TO SIGN/SUBMIT CLAIMS.

I certify that my statements on this claim form are complete and true. I certify that any expenses reimbursed are for Allowable Medical Care Expenses for myself or my Dependent(s) and such expenses have not and will not be reimbursed by any other source or entity, nor be claimed as an income tax deduction.

_____ _____

PARTICIPANT'S SIGNATURE Date

Important Information

- **THE PARTICIPANT must sign and date this form, UNLESS THERE IS WRITTEN AUTHORIZATION ON FILE WITH THE ADMINISTRATIVE OFFICE ALLOWING THE SPOUSE TO SIGN AND SUBMIT CLAIMS.**
- **IF YOU WISH TO AUTHORIZE A SPOUSE TO SUBMIT CLAIMS, PLEASE CONTACT THE ADMINISTRATIVE OFFICE FOR AN AUTHORIZATION FORM.**
- Claims must be received by the Trust Office no later than 12 months from the date of service.
- If the claim is for prescribed over-the-counter medicine, you must submit one of the following items with your claim for reimbursement:
    - A receipt from a pharmacy which identifies the name of the purchase (or name of the person for whom the prescription applies), the date and amount of the purchase, and an Rx number; or
    - A receipt from a pharmacy without an Rx number accompanied by a copy of the related prescription.
- Keep copies of everything submitted
- If you have other insurance coverage that is secondary to this Plan, your claim must be filed with your secondary carrier before your claim for reimbursement is processed. You must submit a copy of the secondary carrier's Explanation of Benefits (EOB) with your claim for reimbursement.
- Please Note:
    - Retiree Medical Premiums for individual health plan policies can only be paid from the Retiree HRA Account
    - If you are a Retiree with both a Retiree and an Active HRA Account, Medical Care Expenses will be paid from your Active HRA Account first.