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

June 2026

TO: HRA Participants of the Local Union No. 598 Plumbing & Pipefitting Industry Health & Welfare Plan & Trust.

RE: Spousal Consent for Health Reimbursement Account(HRA) Claims

Dear HRA Participant,

The Local Union No. 598 Plumbing & Pipefitting Industry Health & Welfare Plan & Trust ("Trust") accepts HRA claims electronically and in paper form. In the event a claim is submitted by paper form, the form requires the Participant's signature. If the Participant's spouse will be submitting and signing HRA claims for your family, the Trust now requires an authorization on file from the Participant (Employee or Retiree).

Please see the enclosed *Spousal Authorization Form*. If you wish to authorize your Spouse to submit claims on behalf of any eligible individual in your household for HRA claims, please complete and return the form to our office.

Please note that, if you do not have a signed Spousal Authorization Form on file, HRA claims must be submitted and signed by the Participant.

As a reminder, the quickest way to get reimbursed is to submit claims electronically to the Trust is through the website www.UA598benefits.org or the Benesys HRA app found in the google or apple store.

Thank you.

The Trust Office

PMB #116, · 5331 S Macadam Avenue Suite 258, · Portland, OR 97239
Toll Free (800) 205-7002 Fax (503) 228-0149
www.UA598benefits.org

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

Spousal Authorization Form
Health Reimbursement Arrangement (HRA)

Completed form 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

SPOUSE Information (Please print legibly):

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

Please check one:

☐ **I AUTHORIZE my Spouse to sign, submit and/or act on my behalf regarding HRA reimbursements for myself, themselves, and/or any eligible dependent children.**

☐ **I REVOKE prior authorization for my Spouse, sign, submit and/or act on my behalf regarding HRA reimbursements for myself, themselves, and/or any eligible dependent children.**

Certification: PARTICIPANT MUST SIGN BELOW.
I certify that my Spouse may sign an HRA Claim form, submit documentation and act on my behalf for HRA reimbursements. This authorization is valid until revoked in writing and submitted to the Administrative Office.

_____ _____
PARTICIPANT'S SIGNATURE Date

Important Information

- **THE PARTICIPANT must sign and date this form.**

Other HRA Reminders:

- 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.

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
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- Keep copies of everything submitted
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- 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.