STEAMFITTERS LOCAL 439 HEALTH & WELFARE FUND

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) REIMBURSEMENT CLAIM FORM

Participant Information:

Name	Telephone Number	ID/SSN Number

Address	City	State	Zip Code

OFFICE USE ONLY
Date received:
Approved by:

HRA Account Expense Claims

Attach appropriate receipt(s) for each expense listed below when submitting this form; please see the reverse side of this form for more details on what to provide.

Date Expense Incurred	**Name of Service Provider**	**Expense Description** (e.g., copay, deductible, coinsurance, self-payment, COBRA premium, dental expense, vision expense, etc.)	**Person for Whom Expense Incurred** (Name/Relationship)	**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 repayment 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 requests for reimbursement on this form, and that I am responsible for payment to any provider from whom a reimbursable expense was incurred. I further understand that if I receive a reimbursement of an expense from my HRA account and it is later determined that the expense was not eligible for reimbursement under the Plan's HRA, I am liable for payment of all related taxes on amounts paid by the Plan that relate to that expense.

Participant's Signature Date

Claim Submission

Attach copies of receipts and other required documentation for listed expenses and send to:

J.W. Terrill Benefit Administrators
Attention: Kathy Jaegers
825 Maryville Centre Dr. Ste. 200
Chesterfield, MO 63017
Fax: (888) 272-7790
Email address: Jennifer.Moyers@marshmma.com
OR Kathy.Jaegers@marshmma.com

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Total				$

Claim and Reimbursement Procedures

To receive reimbursement for eligible expenses, you must submit this Reimbursement 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 provider from whom a reimbursable expense was incurred.

You may request reimbursement up to two times per calendar year. You must have a minimum of $50 in covered health care expenses in order to file a reimbursement request. The amount reimbursed for any eligible expense cannot exceed your HRA account balance at the time reimbursement is requested. You must file this reimbursement claim form within 365 days after the date the expense was incurred or your claim may not be accepted and may be denied. An expense is considered to be incurred on the date the supply is purchased or the service or treatment is received—not on the date that it is paid.

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

- An itemized bill from the service provider that includes the name of the person incurring the charges, date of service, description of services, name of the provider, and amount of the charge.

- An Explanation of Benefits (EOB) from the Plan when requesting reimbursement of the balance of charges that were not paid by the Plan, plus copies of receipts verifying that you paid the balance of the charges.

  Note: If you or your dependents are eligible for other coverage you must include a copy of the 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.

- Proof of the amount and date paid when requesting reimbursement for self-payments for continued coverage under the Plan.

- A receipt and proof of purchase or rental for covered items (such as prescription drugs and medical supplies or equipment, like crutches or a wheelchair).

- Any additional documentation requested by the Plan.

It is a good idea to make a copy of all materials you submit for your records. Materials you submit will not be returned to you.