Electrical Workers Local 369 Benefit Fund

Health Reimbursement Arrangement (HRA) Claim Form

Please check how you prefer to receive your reimbursement check:
____Mail ____Pick-up at Fund Office – Fridays only from 12:00 to 4:00 PM (Member Photo I.D. Required)

Participant Information

Name | *Telephone Number & email address* | ***Social Security Number***

Address | City | State | Zip Code

HRA Account Expense Claims

List below the details of the medical expenses for which you are requesting reimbursement. **Attach appropriate proof of payment for each expense listed**. Refer to the **back of this form for details about acceptable proof of payment** and the claim process. **Your claim must total a minimum of $20 and you need to submit your claim within 12 months of the date the expense was incurred.**

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

Participant Authorization

By signing this form, I certify that my eligible dependent(s) or I incurred these expenses while covered by the Plan. I certify that I have not otherwise been reimbursed for these expenses; these expenses are not eligible for pre-tax payment and have not/will not be taken as a tax deduction. I understand that I am responsible for the accuracy and truthfulness of this claim; I am liable for payment of all expenses and related taxes. **I also authorize the release of additional necessary information from my provider to the Fund Office to process my claim**.

Participant's Signature | Date

The Reimbursement Process

1. Collect your proof of payment, which should be:
   - ***The explanation of benefits (EOB) from your insurance carrier.***
   - ***The receipt from a qualified purchase or the service provider and itemized bill; i.e.***
   - ***Vision claims, dental claims, prescriptions claims (do not send cash register receipts for prescription claims- you must have an itemized statement from the pharmacy or the actual prescription invoice)***

2. Access a claim form by:
   - Picking up the form from the IBEW 369 Local Union or the Fund Office; or
   - Calling the Fund Office at **1-502-635-2611** or **1-800-428-2495** and requesting a form be mailed to you; or
   - Downloading the form from **www.369benefitfunds.com**.
3. Copy this completed claim form and proofs of payment. The Plan will not return these materials.
4. Submit this completed claim form and your proof of payment to the Fund Office by:

Mailing to:	Faxing to:	Emailing to:
Electrical Workers Local 369 Benefit Fund 906 Minoma Ave. Louisville, KY 40217	**1-502-637-3444**	HRAClaims@369benefits.com **New email address effective 4-15-2018**

- Submit your claim for reimbursement within 12 months of the date you incurred the expense.
- Do not submit a claim form totaling less than $20.
- You will not be reimbursed for an amount greater than what is in your HRA account at the time you submit your claim.
- The Plan will directly reimburse you. You are responsible for paying your medical expenses and service providers.
- The money that remains in your account at the end of the year will roll over to the next year.
- If you stop working and continue your coverage through COBRA or if you retire, you can continue submitting claims for reimbursement from your HRA until the account no longer has a balance.
- If there is money in your HRA account when you die, your eligible dependents can continue to submit claims for reimbursement from your HRA to the Fund Office until the account is depleted.

For more information about your Health Reimbursement Account, go to **www.irs.gov** or contact the Fund Office at **1-502-635-2611** or **1-800-428-2495**.