



HOW TO SUBMIT AN HRA CLAIM

Health Reimbursement Arrangement (HRA) allowances may be used to reimburse eligible health expenses incurred by you or any currently enrolled family member and not covered by this Plan or any other health insurance.

How to fill out an HRA Reimbursement Request Form:

- PART 1:** Enter Name, DOB and contact Information for Patient
- PART 2:** Enter Participant (Member) information and Spouse information, if applicable
- PART 3:** Review of Reimbursement Rules and Procedures
- PART 4:** List health care expenses to be reimbursed
- PART 5:** Participant (Member) signs along with Patient if 18 or over



Health Reimbursement Arrangement (HRA) REQUEST FOR REIMBURSEMENT FORM

PART 1 Patient Information

NAME: Harriet Nelson
 DATE OF BIRTH: 01 / 02 / 1976
 ADDRESS: 501 Shatto Place, Suite 500, Los Angeles, CA 90020
 PHONE: (800) 595 - 7473
 RELATIONSHIP: Self Spouse Child
 MARITAL STATUS: Single Married Divorced

PART 2 Participant & Spouse Information

PARTICIPANT		SPOUSE	
NAME: Ozzie Nelson	Harriet Nelson	NAME: Harriet Nelson	Ozzie Nelson
PARTICIPANT ID: T50 012345	Harriet Nelson	PARTICIPANT ID: T50 012345	Harriet Nelson
DATE OF BIRTH: 06 / 01 / 1975	01 / 02 / 1976	DATE OF BIRTH: 06 / 01 / 1975	01 / 02 / 1976
ADDRESS: Same as Above	Same as Participant	ADDRESS: Same as Above	Same as Participant
PHONE: (800) 595 - 7473	(800) 595 - 7473	PHONE: (800) 595 - 7473	(800) 595 - 7473
E-MAIL ADDRESS: ozzienelson25@imagine.com	harrietonelson21@imagine.com	E-MAIL ADDRESS: ozzienelson25@imagine.com	harrietonelson21@imagine.com
EMPLOYER NAME: Copper Plumbing	Early Bird Corporation	EMPLOYER NAME: Copper Plumbing	Early Bird Corporation
EMPLOYER ADDRESS: 12 Pipe Street, Gardena, CA 90247	86 Steeler Road, Brea, CA 92821	EMPLOYER ADDRESS: 12 Pipe Street, Gardena, CA 90247	86 Steeler Road, Brea, CA 92821

PART 3 HRA Reimbursement Procedures

To be eligible for reimbursement, a Request for Reimbursement form must be submitted within 60 months after the date of service. Requests submitted after 60 months will be denied. Large Requests that were initially filed by the 60-month deadline, but which still had a remaining balance after the HRA Allowance was exhausted, may be re-filed indefinitely as new contributions to the HRA Allowance are received.

PART 4 Reimbursement Information

Date of Service	Description or Claim Number	Amount
08/20/2018	Medical Claim #2221133- Medical Deductible	\$250.00
09/05/2018	Medical Claim #2861123- ER Visit	\$391.64
2018	Prescription Claim #2233114- Prescription Deductible	\$50.00
02/01/2019	Vision Claim #2564477- Sore Eyes Vision Care	\$252.00
04/02/2018	Dental Claim #2321415- Smile Dental (EOB Attached)	\$1,250.00

PART 5 Authorization

I/We certify that the foregoing statements, and any accompanying statements, are true, correct and complete to the best of my/our knowledge. I/We hereby certify that the expenses in question were not reimbursed, and are not otherwise reimbursable, in whole or in part, by this or any other plan. I/We hereby authorize the Health & Welfare Fund to use or disclose the information contained in its files in whatever way deemed necessary for the purpose of determining the reasonableness of any of the expenses submitted herewith or the propriety of this reimbursement. I/We understand that the reimbursement will be payable to the Participant.

I/We certify under penalty of perjury under the laws of the State of California that the patient named above meets all the requirements for eligibility under the Plan.

PARTICIPANT SIGNATURE: Ozzie Nelson DATE: 7-1-19
 PATIENT SIGNATURE: Harriet Nelson DATE: 7-1-19

Helpful Hints:

1. One HRA Form must be submitted per patient.
2. There is no minimum request amount.
3. HRA requests must be submitted within 60 months (5 years) from the date of service. Requests submitted after 60 months from date of service will be denied.
4. In order to maximize your HRA Allowance, the Fund Office will attempt to apply all other plan benefits (medical, dental, vision, etc.) before spending your Allowance.
5. An EOB or itemized bill and proof of payment must be submitted with each HRA Form.

Examples of Eligible Out-Of-Pocket Expenses:

- Breast Pumps
- COBRA
- Copayments for Other Insurances
- Deductibles
- Dental Expenses
- Laser eye surgery (Lasik)
- Prescriptions
- Vision Expenses

For more information regarding eligible expenses, download IRS Publication 502 at: tinyurl.com/scptac-p502