4th District IBEW Health Fund

HRA REIMBURSEMENT REQUEST FORM

4th District IBEW Health Fund HRA
3150 US Route 60
Ona, WV 25545
HRA Department
(888) 466-9094
304-525-6005 (fax)
hra@abcwv.com

Complete the Information below for qualifying medical expenses incurred by you, your spouse, or other qualified dependents, for which you request reimbursement payments. Examples of qualifying expenses can be found in the Summary Plan Description (SPD). Be sure to complete all information, only enter the last four digits of your SSN, and include proof of the expense. Proof of expense includes an itemized third party receipt or an explanation of benefits (EOB). Date and sign the form and send the form along with all proof of expense to HRA Department at the above address. We suggest you send copies of the proof of expense as they will not be returned to you.

Name: _____ **SSN**: XXX-XX-_____

Address: _____

_____

Date Of Service Or Date Purchase Made	Provider/Merchant	Individual Receiving Service	Relationship	Type of Expense	Amount Requested

Proof of Expense is required for reimbursement. All uncompleted or undocumented requests will be denied.

I attest that the information stated above is true and I have not been reimbursed previously under this plan or other plan, or expect these amounts to be reimbursed elsewhere. I understand that these expenses cannot also be claimed as a Federal Income tax deduction or credit on my Federal Income Tax Forms.

_____ _____

Employee Signature Date