

St. Louis Graphic Arts Joint Health and Welfare Fund
 1053 Cave Springs Rd. Suite 201
 St. Peters, MO 63376

HRA Claim Form

Participant Information			
Name:	Date of Birth:	SSN:	
Address:			
City:	State:	Zip Code:	Phone:

For each reimbursement you must submit:

- (1) A copy of your Explanation of Benefits (EOB) showing that the amount was applied to your deductible or a printout of a co-pay expense incurred in connection with medical, prescription drug, dental and vision benefits; and
- (2) Proof of payment.

Expenses are not eligible for reimbursement until ALL necessary documentation is received by the Fund Office. Reimbursement is made when reimbursable claims equal \$100 or, if claims total less than \$100, when the claim year closes (March 31).

Qualified HealthCare Expenses Submitted for Reimbursement					
	Patient Name	Date of service	Provider name	Description*	Amount
1					
2					
3					
Subtotal sought on claim form					

* eg Deductible, Co-pay, prescription, dental exam, vision exam

In submitting this form, I certify that

- I have read the eligibility rules on the other side of this form and, to the best of my understanding, all expenses for which I seek reimbursement are for eligible medical expenses for myself, my spouse, or eligible;
- Any dependents for whom I am submitting claims are eligible dependents according the Section 152(a) of the IRS Code and as described in IRS Publication 502;
- none of the expenses for which I seek reimbursement have been or will be reimbursed under any other Health Savings Account, insurance plan or claimed as a deduction on a tax return or tax-deductible plan;
- I understand that a false statement or the withholding of pertinent information may disqualify me from benefits; and
- I understand that IRS regulations require the Fund Office to keep records of all claims and correspondence for three (3) years.

Signature:	Date:
------------	-------

Type of Expenses Eligible for Reimbursement from HRA

- ✓ Deductible and co-payments expenses,
- ✓ incurred in connection with medical, prescription drug, dental and vision benefits,
- ✓ by the Participant or a family member covered through a plan provided through the Participant's employment under a Collective Bargaining Agreement with Local 6-505 (claims incurred by a person covered only by a non-related health and welfare plan are not eligible for reimbursement),
- ✓ Submitted within the time frame below.

Valid Forms of Documentation of Expenses

Documentation Must Include All of the Following:

- ✓ Name of Provider
- ✓ Date(s) of Service
- ✓ Type of Expense (eg office visit)
- ✓ Amount applied to deductible or co-pay
- ✓ Patient Name and Address

Examples

- EOB from TeamCare or other plan provided through the Participant's employment under a CBA with Local 6-505,
- Prescription print out from Pharmacy or Mail Order Pharmacy,
- EOB from Dental Plan provided through the Participant's employment under a CBA with Local 6-505,
- EOB from Vision Plan or itemized statement for glasses/contacts purchased through vision plan provided through the Participant's employment under a CBA with Local 6-505.

Valid Forms of Documentation that Expense Has Been Paid

- ✓ Receipt from Provider showing payment
- ✓ Credit Card receipt showing amount and entity paid (must match amount due on invoice or pharmacy statement)
- ✓ Cancelled check showing amount and entity paid (must match amount due on invoice or pharmacy statement)

When to Submit an Application for Reimbursement

- ✓ The application for reimbursement must be received by March 31 of the year following the year in which the claims are incurred (for example, reimbursement for claims incurred in 2019 must be filed by March 31, 2020),
- ✓ Claims must be paid before seeking reimbursement - reimbursement cannot be made if the amount is still due to the provider, if it is covered by another insurance plan, or if it was paid by a third-party (such as co-pay assist),
- ✓ NOTE: For the September 1, 2018 allocation, Participants will have until March 31, 2020 to seek reimbursement.

When to Expect Payment on Claim for Reimbursement

- ✓ Applications for reimbursement will be reviewed upon receipt and you will be notified if additional information is needed,
- ✓ Reimbursement payments will be issued when the amount of the reimbursement(s) applications for a participant equals the full allocation for that benefit year (\$100 in 2018 and 2019),
- ✓ If a participant's reimbursement applications are less than the full allocation amount for the year (\$100) then payment of the amount claimed will be made as soon as administratively possible after March 31, (there will not be a payment under this provision in March 2018),
- ✓ NOTE: any part of an allocation for which reimbursement is not sought by March 31 of the following year, shall be returned to the general assets of the plan and not available for future reimbursements (this does not apply to the 2018 allocation).