IBEW Local 354 Retiree Fund HRA Account

CompuSys of Utah
PO Box 26237
Salt Lake City, UT 84126

Toll Free (800) 926-5581
Fax (801)975-1342
hradept@compusysut.com

Health Reimbursement Arrangement (HRA) Claim Form

Participant Information

Full Name____SS# ____________________________

Address ____

City_______________________State______Zip Code___________Date of Birth ________________

Phone Number: ________________________________ Email Address: _________________________

Allowable HRA Expense Information

Please complete all of the information for each expense listed below. You must also attach supporting documentation for each expense (for example, Explanation of Benefits (EOB), or itemized bill). It is a good idea to make a copy of all materials you submit for your records. Do not send payment receipts, credit card statements, bank statements, canceled checks or balance forward statements unless they are accompanied by an EOB.

Important Information:

- The Member must sign and date this claim form. (If you are faxing the form and documentation, do not highlight anything as it comes through as black.)
- Claims must be received by the Fund Office within 24 months after the date the expense was incurred.
- If you are requesting reimbursement of your retiree health care coverage, you must provide documentation showing the amount of your self-payment.
- If the claim is for prescriptions, you must submit one of the following items with your claim for reimbursement:
  - A receipt from a pharmacy which identifies the name of the person for whom the prescription applies, the date and amount of the purchase, and an Rx number; or
  - A receipt from a pharmacy without an Rx number accompanied by a copy of the related prescription tag.
- If you have other insurance coverage that is secondary to this Plan, your claim must be filed with your secondary carrier before your claim for reimbursement is processed. You must submit a copy of the secondary carrier's explanation of benefits (EOB) with your claim for reimbursement.

Certification:

I certify that my statements on this claim form are complete and true. I certify that any expenses reimbursed are for Allowable HRA Expenses for myself or my Dependent(s) and such expenses have not and will not be reimbursed by any other source or entity, nor be claimed as an income tax deduction.

_________________________________ _________________________________
Signature Date

Mail your completed form to: CompuSys of Utah, Inc
Attn: HRA Claims
PO Box 26237
Salt Lake City, UT 84126

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List each expense separately (if additional space is needed, make additional copies of this page)

Date(s) Expense Incurred	Name of Service Provider	Expense Description	Person for Whom Expense was Incurred / Relationship to Member	Reimbursement Amount Requested from HRA
1.				$
2.				$
3.				$
4.				$
5.				$
6.				$
7.				$
8.				$
9.				$
10.				$
11.				$
12.				$
13.				$
14.				$
15.				$
16.				$
17.				$
18				$
19.				$
20.				$
21.				$
22.				$
23.				$
24.				$
25.				$
26.				$
27.				$
28.				$
29.				$
30.				$
			Total Requested Reimbursement	$