PLUMBERS LOCAL 68 GROUP PROTECTION PLAN
P. O. BOX 8726
HOUSTON, TX 77249

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) CLAIM FORM

SECTION A — PLEASE COMPLETE ALL SECTIONS

- Only one patient can be listed on a claim form (multiple providers can be listed for that one patient).
- **A minimum of $50 must be accumulated before you submit a claim, unless the balance in your HRA account is less than $50.**
- **Supporting documentation must accompany this claim form. For medical/dental, supporting documentation must include an Explanation of Benefit (EOB(s)) statement or claim number(s) as shown on the EOB from this Plan's Fund Office. For COBRA premiums, check box below, see Section C.**
- Submit this form, with supporting EOB(s) or claim number(s) to the Fund Office, at the above address. Retain copies of supporting documentation for your records.
- **Visit our website www.plu68benefitfunds.com for additional forms, check claim history, claim #'s, and balances.**

SECTION B — EMPLOYEE/PATIENT INFORMATION

Employee's Full Name _____

Employee's ID # _____

Amount You Wish to Withdraw: _____

Daytime Phone (_____) _____ _____
Area Code

CLAIM # / #'S: _____

SECTION C — COBRA PREMIUMS

☐ Check here if you are requesting to pay COBRA premiums from your HRA account

Total Amount of COBRA Premiums to be Paid | $

SECTION D — EMPLOYEE CERTIFICATION

I certify that I and/or my eligible dependents have incurred the expenses for which reimbursement is claimed from the Health Reimbursement Arrangement (HRA) account. I further declare that I have not and will not deduct these expenses on my personal income tax returns, nor have I received reimbursement for these expenses from any other entity. No assignment will be accepted. All payments will be made to the employee.

_____ _____
Employee's Signature Date