Chicago & Vicinity Laborers' District Council

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Health Reimbursement Arrangement (HRA) Program
Request for Reimbursement Form

Member Information

Name — Alt. Member ID Number — Telephone Number

Address — City — State — Zip Code

HRA Expense Claims Attach appropriate receipt(s) for each expense listed below when submitting form. Please see page 2 of this form for more details on what to provide.

PLEASE NOTE: Claims for reimbursement from your HRA Account MUST be received by the Fund Office within one year from the date the expense was incurred. Charges for services rendered more than one year from the date they are received by the Fund Office are not eligible for reimbursement.

Date of Expense	Provider Name[1]	Expense Description	Person for Whom Expense was Incurred	Total Charge (A)	Amount Paid by Other Sources[2] (B)	Amount to be Reimbursed (A – B = C)
				$	$	$
				$	$	$
				$	$	$
				$	$	$
				$	$	$
				$	$	$
				$	$	$
Total HRA Claim						$

[1] Doctor, pharmacy, other health plan, etc.
[2] Other health plan, insurance, Medicare, etc.

Participant Authorization

I certify that the expenses for which I am requesting reimbursement meet all of the following conditions:

- They were incurred for services or supplies provided to me or my eligible dependents under the Plan.
- They were for services or supplies provided on or after the date my HRA Account became effective.
- I have not been, and will not be, reimbursed for these expenses by any other health plan, insurance, or other source or entity.
- I have not deducted, and will not deduct, any of the expenses reimbursed through this Plan on my individual income tax return.
- Premiums submitted for reimbursement were not made through salary reduction contributions under the terms of an IRC Section 125 Plan.

I understand that the Internal Revenue Code permits reimbursement only for eligible health care expenses, which means amounts paid for diagnosis, cure, mitigation, treatment or prevention of disease. I understand that I alone am fully responsible for the sufficiency, accuracy, and truthfulness of all information relating to the claims on this form and that I am liable for payment of expenses. I also understand that if an expense is not eligible for reimbursement under the Planôs HRA Program, I am liable for payment of all related taxes on amounts paid by the Plan that relate to these expenses.

Memberôs Signature — Date

Claim and Reimbursement Procedures

To receive reimbursement for eligible expenses, you must submit this written form, with the required supporting documentation, to the Fund Office in accordance with the claim procedures described in your HRA Program booklet. Reimbursement is paid directly to you; you are responsible for paying any providers.

All expenses must be incurred prior to being considered for reimbursement except for certain advance payments for orthodontia services. Incurred refers to the date you or your dependents received goods or services. This date could be different from the date you are billed for or paid for the expense.

PLEASE NOTE: Claims for reimbursement from your HRA Account MUST be received by the Fund Office within one year from the date the expense was incurred. Charges for services rendered more than one year from the date they are received by the Fund Office are not eligible for reimbursement.

Along with this form, you must provide the following, as applicable:

1) An itemized bill from the service provider that includes the name of the person incurring the charges, date of service, description of services, name of provider, and amount of charge.
2) An Explanation of Benefits (EOB) when requesting reimbursement of the balance of charges for which coverage is available from either this Plan or another plan, plus original receipts verifying payment. Only eligible expenses that have not been reimbursed, as shown on the EOB, will be eligible for reimbursement.
3) Proof of the amount, the name of the covered person, date paid, and coverage period when requesting reimbursement for other insurance premiums, such as a spouse's group health coverage premiums, and verification that the premium was not paid or eligible for payment under an IRC Section 125 Plan. Additional documentation is also required for reimbursement of premiums under a qualified long-term care contract.
4) A receipt and proof of purchase or rental for covered items (such as for crutches or wheelchairs).
5) A receipt on which the name of the product has been imprinted by a cash register for over-the-counter medicines and medical supplies. Unreasonable quantities of such items cannot be reimbursed under IRS rules.
6) Any additional documentation requested by the Plan.

It's a good idea to make a copy of all materials you submit for your records. Materials you submit will not be returned to you.

As a reminder, reimbursements for expenses related to long-term care services and for premiums paid through salary reduction contributions to an IRC Section 125 Plan are not allowed. In addition, reimbursements for deductibles and co-payments for services received from non-network providers are limited to the amounts that would be reimbursable from your HRA Account if you had gone to an in-network provider.

While IRS Publication 502 is helpful in determining whether a medical expense may be reimbursed under the HRA Program, its information is not completely consistent with the rules that apply to the HRA Program. IRS Publication 502 applies to tax deductible expenses for federal income tax purposes, so some items listed are not eligible for reimbursement under the HRA Program because the HRA Program is subject to additional IRS requirements. For instance, the HRA Program cannot reimburse long-term care expenses or premiums paid through salary reduction contributions to an IRC Section 125 Plan. As another difference, IRS Publication 502 states that nonprescription drugs are ineligible. However, you may be reimbursed for expenses for over-the-counter drugs and medical supplies under the HRA Program so long as they are for the diagnosis or treatment of a medical condition and not only for your general well being. Finally, the HRA Program has the right to deny reimbursements for certain expenses even though they may be allowed under federal law. You are notified of such limitations prior to their implementation.

Claim Submission

Mail the completed form and supporting documentation to:

Chicago Laborersô Welfare Fund
11465 W. Cermak Road
Westchester IL 60154
708-562-0200