IBEW Local 347 Electrical Workers
Health and Welfare Fund

PO Box 26068
Salt Lake City, UT 84126-0068

CompuSys of Utah, Inc.

Toll Free (844) 347-IBEW (4239)
Fax (801)975-1342

Health Reimbursement Arrangement (HRA) Claim Form

Participant Information

Full Name_____ SS# _____

Address _____

City_____ State_____ Zip Code_____ Date of Birth _____

Member Identification #:_____ Phone Number: _____

Email Address: _____

Allowable HRA Expense Information

Please complete all of the information for each expense listed on the back side of this form. 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 12 months after the date the expense was incurred.
- 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
P.O. Box 26068
Salt Lake City, UT 84126-0068

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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 Reimbursement from HRA (minimum reimbursement is $25.00)				$