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

Heath Reimbursement Arrangement (HRA) Claim Form for Authorization of Automatic Monthly Premium or Retiree Premium Payments

If you are a Covered Employee, Retiree or surviving spouse, and you will not have sufficient contributions in your Dollar Bank (or in the case of a surviving spouse, the deceased Participant's Dollar Bank) to pay the Monthly Premium or Retiree Premium (as applicable) for the next month, you may authorize the Plan Administrator to automatically draw the Monthly Premium or Retiree Premium (as applicable) from your (or in the case of a surviving spouse, the deceased Participant's) HRA Account to pay for coverage for you and your Dependents. To provide this authorization, please complete this claim form and return it to the address listed at the bottom of this form.

If you do not want Monthly Premium or Retiree Premium payments automatically drawn from your HRA Account, do not fill out this form.

1. Participant Information

Full Name_____ SS# _____

Address_____

City_____ State_____ Zip Code_____ Date of Birth_____

Member Identification #:_____ Phone Number:_____

2. Health Reimbursement Arrangement (HRA) Automatic Payment

☐ I want my Monthly Premium or Retiree Premium (as applicable) paid automatically from my HRA Account. I understand that in the event that I do not have sufficient contributions in my Dollar Bank to pay the Monthly Premium or Retiree Premium (as applicable), the Plan Administrator will automatically draw the Monthly Premium or Retiree Premium from my available HRA Account balance.

3. Participant Authorization

I certify that my statements on this claim form are complete and true. I certify that the Monthly Premium or Retiree Premium amount has not and will not be reimbursed by any other source or entity nor claimed as an income tax deduction.

_____ _____

Participant Signature Date

Mail your completed form to: CompuSys of Utah, Inc
P.O. Box 26068
Salt Lake City, UT 84126-0068

This authorization is effective on the date it is received by the Fund Office and will remain in effect for one year. After one year, you may submit a new Claim Form for Authorization for Automatic Monthly Premium or Retiree Premium Payments. Please retain a copy for your records.