

PLUMBERS AND PIPEFITTERS LOCAL 162 INSURANCE FUND

Health Reimbursement Account Request

- Complete and sign this form.
- Send the completed Request Form and other materials to:

Plumbers and Pipefitters Local 162 Insurance Fund
1200 East Second Street
Dayton, Ohio 45403

- Attach an itemized receipt from the doctor, dentist or other supplier which identifies the person receiving the service or a copy of the Explanation of Benefits Statement denying the charge. Keep copies of your receipts or benefits statements for your records. Those you submit will not be returned.

EMPLOYEE'S NAME: _____

EMPLOYEE'S SOCIAL SECURITY NUMBER: _____

EMPLOYEE'S ADDRESS: _____

DAYTIME TELEPHONE NUMBER: _____

PLEASE NOTE:

- Expenses that may be reimbursed are those medical, dental and optical expenses you or your eligible dependent have which are not covered or not paid by any other portion of the Plumbers and Pipefitters Local 162 Insurance Fund or any other plan. Expenses which are applied to a deductible, co-payment or coinsurance amount, as well as COBRA and Retiree self-pay amounts are also eligible for reimbursement.
- You must have been eligible for coverage under the Plumbers and Pipefitters Local 162 Insurance Fund at the time the expense was incurred.
- You must submit your claim no later than March 31st of the year after the year in which the expense was incurred.
- You must submit at least \$25 in eligible expenses before payment will be made.

I certify that either I and/or my eligible dependents have incurred the expenses for which reimbursement is claimed from the Health Reimbursement Account and I further declare that I have not and will not deduct these expenses on my individual Income Tax Returns. No assignment will be accepted. All payments will be made to the employee.

EMPLOYEE'S SIGNATURE: _____

DATE: _____