SAN FRANCISCO ELECTRICAL WORKERS
HEALTH & WELFARE TRUST

HEALTH REIMBURSEMENT ARRANGEMENT CLAIM FORM

Instructions: To receive a reimbursement from your Health Reimbursement Arrangement (HRA) account, complete a separate form for each person receiving services. For co-payments, the preferred documentation is your Explanation of Benefits (EOB) or, for drug prescriptions, a copy of the drug label stub or pharmacy printout. Documentation must name the person treated, the name of the service provider, the amount required to be paid by the participant or dependent, insurance coverage, and the nature and date of the service. You may not claim reimbursement for any expense to the extent it was reimbursed by insurance or another plan. Orthodontic services will be reimbursed only after services are rendered. If your documentation is insufficient, you will receive a request for more information.

Generally, reimbursements for eligible claims filed by the end of a month with all necessary documentation will be issued by the 15th of the next month. All reimbursement will be made payable to the member.

Member Name: _____ Member SS# (Last 4 digits):_____

Address: _____

Telephone: (H) _____ (W) _____

Person Treated:_____Date of Birth _____Relationship to Member: _____

Type of Service	Provider's Name	Date of Service	Amount of Claim
_____	_____	____/____/____	_____
_____	_____	____/____/____	_____
_____	_____	____/____/____	_____
_____	_____	____/____/____	_____
_____	_____	____/____/____	_____

Total $_____

Member Certification:

To the best of my knowledge, the statements in this form are true and complete. I certify that:

- Either I, my spouse or my dependent has received the services described above on the dates indicated.
- The expenses are Medical Care Expenses under tax code §213(d) as defined in IRS Publication 502 (see https://www.irs.gov/pub/irs-pdf/p502.pdf.
- These expenses were neither incurred for cosmetic or general health purposes, nor constitute toiletries.
- These expenses have not previously been reimbursed under any other plan, and I will not seek reimbursement for them under any other health plan or source (including manufacturer rebates).
- I understand that these expenses may not be used to claim any federal income tax deduction or credit.
- I understand that I may be asked to provide further details about these expenses.

Member Signature: _____ Date: _____

Return this completed form with documentation to: Kaufmann & Goble, 160 W. Santa Clara St., Suite 1550, San Jose, CA 95113
Fax:(408) 298-1180 or e-mail:SFEWHRA@kandg.com

For Administrative use only:

Control ID: _____ Processing Date: _____ Disp:_____ Init:_____