CLAIM FOR HRA PREMIUM PAYMENT
IBEW LOCAL 617
HEALTH REIMBURSEMENT ACCOUNT CLAIM FORM

Name_____ Social Security #_____

Street Address_____

City, State, Zip Code_____

Complete only the section that apply to the claim you are submitting for reimbursement. Part 1 is for Authorization to Deduct Self Payment Amounts from your HRA Account to continue coverage. *Please note that the HRA Funds are part of the Trust and that an HRA Account balance is not a vested benefit.*

The undersigned participant in the plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form are for covered medical expenses. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including Federal, State or City Income Tax on amounts paid from the Plan which relate to such expense. It is the member's responsibility to keep copies of all claim forms and receipts for potential IRS Audits.

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PART 1: AUTHORIZATION TO DEDUCT SELF PAY PREMIUM FROM EXTENDED RESERVE ACCOUNT

My signature below is authorization to have the monthly premium amount required for Active Member self payment, Retiree Premium or COBRA coverage to be deducted from my HRA Account. I understand that payment deduction from my HRA Account will continue only under the terms of the IBEW Local 617 Health and Welfare Trust Fund rules of Self Payment and COBRA coverage. The authorization is for continuation of coverage as checked below. I may continue Medical Only Coverage or Medical and Dental Coverage. I may not continue Dental Only coverage.

Please check only one option:

I elect deduction of the required Medical Only Coverage: _____

I elect deduction of the required premium for Medical and Dental Coverage: _____

This authorization will remain in effect until the earliest of the following; a) such time as I am no longer eligible to continue coverage under the self pay rules or COBRA coverage, b) my HRA Account balance is exhausted or c) I rescind the authorization in writing. I understand if I rescind this authorization prior to the end of the period allowed by self pay rules, I can not later elect to use the HRA Account for any remainder of that entire period.

_____ _____

Employee's Signature **Date**