IBEW Local 40-NECA Health Trust Fund

Health Reimbursement Account

Administered by Coast Benefits, Inc.

Health Reimbursement Arrangement (HRA) Claim for Reimbursement

Participant Information:

Name ***Telephone Number*** ***Social Security Number***

Address ***City*** ***State*** ***Zip Code***

HRA ACCOUNT EXPENSE CLAIMS - Attach appropriate receipt(s) for each expense listed below when submitting form; please see the reverse side of this form for more details on what to provide. **Requests for reimbursement must total a minimum of $25.00.**

Select a Payee – Circle one – Pay to: Me or Provider Payee Information:_____

Date you received the service	Service Provider	Expense Description	Person for whom Expense Incurred	Expense Amount
				$
				$
				$
				$
				$
				$
				$
				$
Total				**$**

Participant Authorization

By signing below, I certify that all services for which reimbursement is requested on this form were provided while I was eligible for coverage under the IBEW Local 40 - NECA Health Trust Fund Summary Plan Description ("SPD") and were for me or my eligible dependents, as defined by the SPD. Further, I certify that the eligible expenses have not been otherwise reimbursed, nor will they otherwise be reimbursed, through any other source, have not been paid or are not eligible for payment on a pre-tax basis, and have not been taken, nor intend to be taken, as a tax deduction. I understand that the Internal Revenue Service Code permits reimbursement only for eligible health care expenses. I understand that I alone am fully responsible for the sufficiency, accuracy, and truthfulness of all information relating to the claims on this form and that I am liable for payment of expenses and that if an expense is not eligible for reimbursement under the Plan's HRA Account, I am liable for payment of all related taxes on amounts paid by the Plan that relate to these expenses.

Participant's Signature **Date**

Mail or Fax Completed form and any required documentation to:

Coast Benefits, Inc.
HRA Claims Department
3530 Camino Del Rio North, Suite 110
San Diego, California 92108
Telephone: 844-739-7956 • Fax: 1-877-501-1015

Claim and Reimbursement Procedures

To receive reimbursement for eligible expenses, you must submit this written claim form, with the required supporting documentation, to the Plan in accordance with the Plan's claim procedures as briefly described here and in more detail in your Summary Plan Description. It is very important for you to enter the correct date of service for each claim. **The IRS only allows reimbursement payments paid directly to you or a provider and only after you have provided the Fund with proof of payment made to your providers.**

While you can submit requests for reimbursement at any time, **the IBEW Local 40 - NECA Trust Fund SPD requires that any requests for reimbursement be for a minimum of $25.00.** Therefore, you will have to hold your requests for reimbursement until you have at least $25 in eligible expenses. In addition, the amount reimbursed for any eligible expense will not exceed your HRA Account balance at the time reimbursement is requested.

Along with this form, you must provide any of the following, as applicable:

An itemized receipt from the service provider that includes the name of the person incurring the charges, date of service, description of services, name of provider, and amount of charge.

An Explanation of Benefits (EOB) from any coverage (including any EOB issued by the IBEW Local 40-NECA Health Trust Fund) when requesting reimbursement of the balance of charges for which coverage is available plus original receipts verifying payment.

Prescriptions for medication and glasses.

Any additional documentation requested by Coast Benefits HRA Department.

A copy of both the front and back of a "canceled check" will be accepted as proof of payment along with an itemized receipt of services.

It's a good idea to make a copy of all materials you submit for your records. Materials you submit will not be returned to you.