SOUTHERN CALIFORNIA PIPE TRADES HEALTH & WELFARE FUND
(For Active Participants & Eligible Dependents)

501 Shatto Place, 5th Fl., Los Angeles, CA 90020
(800) 595-7473 (213) 385-6161
Fax:(213) 487-3640 www.scptac.org

Health Reimbursement Arrangement (HRA)

REQUEST FOR REIMBURSEMENT FORM

✚ This Form is necessary for the Fund to determine eligibility for HRA benefits. ✚ All sections must be completed. ✚ Submit this form only if you have $25 or more in expenses eligible for reimbursement. ✚ Supporting documents for each expense must be included with this form. ✚ Failure to complete and sign this form will delay the processing of your reimbursement.

PART 1 Patient Information

NAME		
DATE OF BIRTH	*mm/dd/yy* / /	**GENDER** ☐ Male ☐ Female
ADDRESS *If different from Participant*	*Street, City, State, ZIP*	
PHONE	( ) -	
RELATIONSHIP *(To Participant)*	☐ Self ☐ Spouse ☐ Dependent	**MARITAL STATUS** ☐ Single ☐ Married ☐ Divorced

PART 2 Participant + Spouse Information

	PARTICIPANT	**SPOUSE** *(required whether or not spouse is patient)*
NAME		
PARTICIPANT ID	T	T
DATE OF BIRTH	*mm/dd/yy* / /	*mm/dd/yy* / /
ADDRESS	*Street, City, State, ZIP*	*Street, City, State, ZIP*
PHONE	( ) -	( ) -
E-MAIL ADDRESS	*(Optional)*	
EMPLOYER NAME		
EMPLOYER ADDRESS	*Street, City, State, ZIP*	*Street, City, State, ZIP*
EMPLOYER PHONE	( ) -	( ) -

PART 3 Reimbursement Information

Please list the expenses for which you are requesting reimbursement. List the date of service (date expense was incurred), a brief description of the type of expense (for example, prescriptions, deductibles, co-payments, dental or vision expenses), and the total amount requested for that type of expense. Each item must be accompanied by proof of payment and documentation of the expense. Please list each expense amount on a separate line. Attach additional pages if needed.

Date of Service	Description	Amount

PART 4 Authorization

I/We hereby certify that the foregoing statements, including any accompanying statements, are true, correct and complete to the best of my/our knowledge. I/We hereby certify that the expenses in question were not reimbursed, and are not reimbursable, in whole or in part, by this or any other plan. I/We hereby authorize the Health & Welfare Fund to use or disclose the information contained in its files in whatever way deemed necessary for the purpose of determining the reasonableness of any of the expenses submitted herewith or the propriety of this reimbursement. I/We understand that the reimbursement will be payable to the Participant.

I/We certify under penalty of perjury under the laws of the State of California that the patient named above meets all the requirements for eligibility under the Plan.

PARTICIPANT SIGNATURE *Required*	DATE	PATIENT SIGNATURE *Not Required, if under 18 years of age*	DATE
X		X	

PART 5 HRA Reimbursement Procedures

An HRA Allowance may be used to reimburse eligible health care expenses incurred by the Participant, Spouse or eligible Dependents which are not covered or reimbursed in full by this Plan or any other health plan or insurance policy. Reimbursable expenses are those that constitute "medical care" under Section 213 of the Internal Revenue Code. For example, HRA Allowance may be used to reimburse the Participant for Plan deductibles, co-payments, and other non-covered expenses for medical, prescription drug, dental, vision, and psychiatric services. An HRA Allowance may also be used to reimburse self-pay premiums, COBRA premiums, other medical plan coverage, Medicare supplemental coverage, Medicare Part B or D monthly payments, and long-term care insurance premiums (but not life insurance premiums). No benefit will be paid from a Participant's HRA Allowance in an amount less than $25.00.

To be eligible for reimbursement: (1) the expenses must be submitted within 12 months after the date of service. Claims Requests submitted after 12 months will be denied. Large requests that were initially filed by the 12 month deadline but which still had a remaining balance after the HRA Allowance was exhausted may be re-filed indefinitely as new contributions to the HRA Allowance are received; (2) Supporting documentation must be provided together with this form, describing the expenses and proving that the Participant (or eligible Spouse or other eligible Dependent) paid the expenses. Supporting documentation may include, but is not limited to: (a) an itemized bill describing the services provided, the person to whom the services were provided, the name of the provider, the date of service, and the charged amount; (b) an Explanation of Benefits (EOB); and (c) a receipt showing proof of payment.