SOUTHERN CALIFORNIA PIPE TRADES HEALTH & WELFARE FUND

501 Shatto Place, 5th Floor, Los Angeles, CA 90020 | (800) 595-7473 (213) 385-6161 | Fax (213) 385-2767 | www.scptac.org

Health Reimbursement Arrangement (HRA)
Subsidized Self Pay / COBRA
AUTOMATIC PAYMENT FORM

SECTION 1—PARTICIPANT INFORMATION

_____
Participant Name

_____
Phone Number and/or Email Address

_____
Social Security Number (only last 4 digits required)

OR

T500-_____
Blue Shield ID Number

SECTION 2—DIRECTION AND CERTIFICATION

I hereby direct the Southern California Pipe Trades Health & Welfare Fund to pay my SSP or COBRA premiums from my HRA Allowance.

I 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 understand that:
- A new automatic premium payment form will be required for any plan changes, including COBRA election after any Subsidized Self Pay eligibility period ends.
- Premium reimbursements will only be deducted when the available HRA Allowance is equal or greater than a full month's premium.
- The premium reimbursement will be retained by the Southern California Pipe Trades Health and Welfare Fund.
- Premium reimbursements will be processed on or about the 20th of the month prior to the month of coverage.
- HRA claims are processed in the order that they are received and any additional claims submitted may deplete the HRA allowance and thereby prevent the payment of my SSP or COBRA premium.
- If there are insufficient funds in the HRA Allowance, it is my responsibility to pay the premium by the applicable deadline.

I certify under penalty of perjury under the laws of the State of California that:
- The foregoing statements, and any accompanying statements, are true, correct and complete to the best of my knowledge.
- My SSP or COBRA premiums were not reimbursed, and are not otherwise reimbursable, in whole or in part, by this or any other plan.
- I meet all the requirements for eligibility under the Plan.

X_____
Signature

_____
Date