IE SHAFFER
PLAN ADMINISTRATORS

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IBEW Local 400 Supplemental Fund
Health Reimbursement Arrangement (HRA)
Claim Form

See the back side of this form for instructions. Please complete the form and then send it, along with your receipts, to:
I E Shaffer & Co P.O. Box 1028 West Trenton, NJ 08628 Attn: Linda Lawson

Your Name ____________________ Social Security # ____________________

Telephone # ____________________

Home Address ____________________

City ____________________ State __________ Zip __________

Expense Information (please print)

Complete the following information for each claim expense item. If you have multiple items of similar types of service (for example, six prescriptions), you may combine them on one line. Attach supporting documentation for each expense. The claim form and documentation must list the date(s) that the expense was incurred, provider name, type of service, patient name, and your portion of the charge for the service.

Date Expense Incurred (mm/dd/yy)	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount
			Total Requested Reimbursement Amount	

Certification

I authorize my Health Reimbursement Arrangement (HRA) to be reduced by the amount of expenses listed above. I certify that all expenses for which reimbursement is claimed have been incurred and have not been reimbursed and are not reimbursable under any other health plan. I understand that I am required to submit, in addition to this claim form, an itemized receipt or an Explanation of Benefits from my insurer. I represent that any individual (other than the employee or employee's spouse) for whom a claim is filed hereunder, qualifies as a dependent of the employee for federal income tax purposes. I further declare that I have not and will not deduct these expenses on my federal, state, or local income tax returns.

Employee Signature (Required)	Date

Important HRA Claim Submission Information

Definition of "Incurred"

The term "incurred" refers to the date you or your eligible dependent is provided with the care that gives rise to the medical, dental, vision, prescription, or other qualifying expense. This date could be different than the date you are billed or pay for the expense.

Helpful Hints on How to Successfully File a Claim

- The list of eligible medical and dental expenses for which you may seek reimbursement are detailed in **IRS Publication 502 "Medical and Dental Expenses"** which can be found at www.irs.gov/publications/p502/index.html.

- The documentation must clearly list the date the service was incurred, provider name, type of service, patient name, and your portion of the charge for the service.

- If the expense incurred is reimbursable by your welfare fund or other insurance, you must submit the expense to your welfare fund and/or insurance company first. You can then use the Explanation of Benefits (EOB) received from the welfare fund or insurance company as your expense documentation. The EOB that you receive from your welfare fund or insurance company is the best source of expense documentation for use in submitting your claims.

- Cancelled checks, "balance forward" statements, "previous balance" statements, "paid on account" statements or receipts, charge card receipts, or charge card statements are not acceptable forms of expense documentation according to the IRS as they do not clearly indicate the date or type of service.

- For prescription expenses, submit the prescription receipt you received with the medication purchased showing the patient name, medication name, the date the prescription was filled, and the amount owed for the medication. Cash register receipts or charge slips for prescription purchases cannot be accepted as they do not indicate the medication name or patient.

- Claims can be submitted at your convenience but must be for at least $100. To be eligible for reimbursement, claims must be submitted within two years from the date the expense was incurred.

- Keep copies of your claims.

- Send your completed claim form along with your receipts to :

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