

IBEW LOCAL 7 HRA SUBMITTAL FORM

NAME: _____ Soc. Sec#: _____
 Address: _____ City: _____
 State: _____ Zip: _____ Home Phone: _____ Mobile: _____

Covered Expenses (Please include all receipts with form. Receipts are valid for 18 months, no earlier than 9/1/07)

\$	<u>Amount</u>	Type: <u>co/pay, dental, prescription etc...</u>	Date: <u>of service</u>	For: <u>Name of dependant/self</u>
\$		Type: _____	Date: _____	For: _____
\$		Type: _____	Date: _____	For: _____
\$		Type: _____	Date: _____	For: _____
\$		Type: _____	Date: _____	For: _____
\$		Type: _____	Date: _____	For: _____
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\$		Type: _____	Date: _____	For: _____
\$		Type: _____	Date: _____	For: _____
\$		Type: _____	Date: _____	For: _____
\$		Type: _____	Date: _____	For: _____
\$		Total Expenses <i>(Must total \$100 or more per form)</i>		

Claims for reimbursement will be processed quarterly, and must be submitted on or before January 1, April 1, July 1 and October 1 of each year. Each of the Expenses listed have not otherwise been reimbursed and are not reimbursable through any other source and health FSA coverage, if any, for such Expenses has been exhausted. I am aware that the fund is regulated by the rules and laws set forth in the Summary Plan Description and Publication 969 of the IRS. I hereby attest all information submitted to be true and accurate to the best of my knowledge.

Signed: _____ Date: _____

