PAGE____of _____ Revised 9/1/14

IBEW LOCAL 7 HRA SUBMITTAL FORM

NAME: ____ Last 4 of SS#__________

Address: ________________________________ City: ____________________

State: ________ Zip: __________ Home Phone: _________________ Mobile: _________________

Covered Expenses (Please include all receipts with form. Receipts are not valid prior to becoming a plan participant)

**Amount** **Co/pay, premium/COBRA, RX etc…** **Service** **Name of covered Dependent**

___ $ ____________ Type: _____________________ Date: __________For: _____________________
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$__________________ Total Expenses (***Must total $100 or more per Submittal***)

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. By signing below, I attest that each of the Expenses listed above 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 IBEW Local 7 HRA is regulated by the rules and procedures set forth in the Summary Plan Description and Publication 969 of the IRS. I further attest that I am currently covered by a group health plan in compliance with the ACA's prohibition on "dollar limits", its preventative services requirements and its minimum value standards. I hereby attest all information submitted to be true and accurate to the best of my knowledge.

Member Signature: ______________________________________ Date: ____________________

Mail to: AJE Financial (ATTN: Michelle), 588 Center St, Ludlow, MA 01056