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: _____
___	$ _____	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: _____
___	$ _____	Type: _____	Date: _____	For: _____

$_____ 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. 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 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.

Members Signature: _____ Date: _____

MAIL TO: IBEW LOCAL 7/HRA 95 LIBERTY STREET SPRINGFIELD MA 01103