UFCW Local 152 HEALTH AND WELFARE FUND

27 Roland Avenue, Suite 100, Mount Laurel, NJ 08054 • 1-800-555-4959 or 1-856-793-1598

Health Reimbursement Account (HRA) Claim Form

Mail, fax or email completed form and documentation to: 27 Roland Avenue, Suite 100, Mt. Laurel, NJ 08054
Fax: 856-793-3102

1. Please print clearly. All information in each section must be completed.
2. Attach required documents. Refer to eligible expenses on the reverse side of this form.
3. The participant must sign each Claim Form that is submitted. Reimbursement will not be processed without a signed form.

PARTICIPANT INFORMATION		
Participant's ID (Social Security Number)		Participant's Date of Birth (MM/DD/YYYY) / /
Participant's Name (Last, First, Middle Initial)		
Address		Daytime Phone
City	State	Zip
Employer		Local Union Number

I certify that the expenses for which I am seeking reimbursement have been incurred by me, my eligible spouse or other eligible dependent. The patient named below is eligible for benefits and did, in fact, receive the services listed. I certify that these expenses have not been reimbursed, nor will they be reimbursed, under any other benefit plan. I agree to submit and retain sufficient documentation for any expenses for which I seek reimbursement.

Participant Signature ______________________________ Date ______________

The below section must be completed only for eligible expenses (as listed on the back of this form) and only for expenses incurred during your plan year. You must have been a participant in the plan at the time the expense was incurred. The incurred date of the expense is the date of service.

An itemized receipt/statement for each amount requested or an Explanation of Benefits (EOB) from your insurance company must be attached in order for your claim to be processed.

EXPENSE INFORMATION			
Patient's Name		Relationship to Employee ☐ Self ☐ Spouse ☐ Dependent	Date of Birth (MM/DD/YYYY) / /
Provider	Type of Service	Date of Service (MM/DD/YYYY) / /	Total Amount Submitted $
Patient's Name		Relationship to Employee ☐ Self ☐ Spouse ☐ Dependent	Date of Birth (MM/DD/YYYY) / /
Provider	Type of Service	Date of Service (MM/DD/YYYY) / /	Total Amount Submitted $
Patient's Name		Relationship to Employee ☐ Self ☐ Spouse ☐ Dependent	Date of Birth (MM/DD/YYYY) / /
Provider	Type of Service	Date of Service (MM/DD/YYYY) / /	Total Amount Submitted $
Patient's Name		Relationship to Employee ☐ Self ☐ Spouse ☐ Dependent	Date of Birth (MM/DD/YYYY) / /
Provider	Type of Service	Date of Service (MM/DD/YYYY) / /	Total Amount Submitted $