LOCAL UNION 373 HEALTH & WELFARE FUND
HEALTH REIMBURSEMENT ACCOUNT PROGRAM (HRA FUND)

P.O. BOX 58, MOUNTAINVILLE, NY 10953 - (845) 534-9522

(This section for office use only)

Member #: _____ Check Date: _____

Name: _____ SS#: _____ LU#: _____

Address: _____ _____ _____ _____
Street City State Zip Code

ECONOMIC ASSISTANCE---------- AMOUNT REQUESTED $_____

Reimbursable Economic Benefits:

- Out of pocket medical:
  - Doctor Bills
  - Hospital Bills
  - Prescription Drug Co-pay(s)
  - Dental Bills
  - Optical Bills
- Health Insurance Premiums:
  - Retiree Health Insurance Co-pay
  - Medicare Part "B"
  - COBRA Insurance Premiums
  - Supplemental Health Insurance Premiums

ONLY ORIGINAL PAID BILLS WILL BE ACCEPTED FOR REIMBURSEMENT

I certify that the information on this form, and any attachments is accurate and complete. I am requesting reimbursement for eligible medical expenses incurred by myself or an eligible dependent. I, or my dependents, have already received the product(s) or service(s) and have not and will not seek reimbursement of these expenses from any other plan or party. I have not and will not claim these expenses as a tax deduction under IRS code 213.

I understand that submitting a fraudulent claim or falsifying information may result in the forfeiture of ay funds in my HRA account and I give permission to the Welfare Fund to verify the information submitted as determined by the Welfare Fund in its discretion.

Original paid bills, with proof of payment and service date are attached.

I hereby agree to reimburse the Welfare Fund for any sums it pays in reliance on these certifications if they prove to be inaccurate or false, and to indemnify the Trustees of the Welfare Fund and hold them harmless, against any costs, expenses and damages they may incur or suffer as a result of any such inaccuracy or falsity.

Signed: _____ **Date:** _____

☐ I will pick up my check at the Fund Office	☐ Please mail my check	☐ Direct Deposit

TRUSTEE APPROVAL: _____

Form Updated 01/23/25