PIPEFITTERS WELFARE FUND, LOCAL 597
ACTIVE HEALTH REIMBURSEMENT (HRA) CLAIM FORM
(RETIRED MEMBERS ONLY WITH ACTIVE HRA BALANCE)

Phone (312) 633-0597 - Fax (312) 829-7787

www.pf597.org

Member's Name _____

First Last Phone Number

Address _____

Street City State Zip Code

_____or_____

Soc. Sec. Number U.A. Card Number Date of Birth

Expense Information (please print)

Complete the following information for each claim expense item. If you have multiple items of similar types of service (for example, six prescriptions), you may combine them on one line. Attach supporting documentation for each expense (for example, itemized bill, proof of payment or Explanation of Benefits (EOB) from your or your spouse's insurance company or proof of premium payment.

Date Expenses Incurred (mm/dd/yy)	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Claim Amount
		Total Requested Reimbursement Amount		**$**

This is to certify that my statements on this Claim form are complete and true. I certify that any expenses reimbursed are for eligible medical expenses for myself, my spouse, or eligible dependents and such expenses have not and will not be reimbursed under any other Health Reimbursement Account, insurance plan, nor be claimed as an income tax deduction.

Member's Signature Date