Pipe Fitters' Welfare Fund, Local 597

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Health Reimbursement Account (HRA) Claim Form

(FORMER LOCAL 422)

Member's Name _____ (First) _____ (Last) _____ (Phone Number)

Address _____ (Street) _____ (State) _____ (Zip)

_____ (Social Security Number) or _____ (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.

For information regarding eligible medical expenses please refer to the next page.

QUALIFIED HEALTH CARE EXPENSES

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)