This form has been enhanced with input fields for your convenience. Please use the TAB key to move to the next field or hold down the SHIFT key and press TAB to move to the previous field.

You may Fill it out and then Print the form.

OR

Print this form and then fill it out.

After it has been printed, please SIGN and MAIL it to the Iron Workers Benefit Trust.

Iron Workers District Council of Southern Ohio and Vicinity Benefit Trust

HEALTH REIMBURSEMENT ACCOUNT CLAIM FORM
PREMIUM PAYMENT

Fax or Mail Claim Form to: Iron Workers Benefit Trust
Main PO Box 398 — Dayton, OH 45401-0398
Fax: 937-454-5457

Participant Name (Print)

- - / / /

Social Security No./Health ID No. Date of Birth

Address

Note: The system will format the Phone Number - JUST ENTER THE NUMERIC DIGITS with Area Code.

City, State, Zip Phone No.

Certification and Authorization:

I certify that the information on this form is accurate and complete. ***I am authorizing payment to continue health care coverage for myself or my eligible dependent(s) under the Iron Workers District Council of Southern Ohio and Vicinity Benefit Trust. I authorize my full HRA balance be deducted and applied toward Retiree Premium payments if that type of premium is chosen.***

Participant Signature Date

Month(s) of Coverage

This does not guarantee you have HRA to cover the premium payment. You may call the Trust Office @ 800-331-4277 for your balance as of that date.

Premium Cost $

Type of Premium:

- ☐ Self-Payment
- ☐ Supplemental Payment
- ☐ Retiree Premium

TOTAL REQUESTED REIMBURSEMENT EQUALS $
(must be greater than $25.00)

Note:

You may select or un-select the 'Check Box options' to the left by positioning your mouse cursor on the 'Check Box' and clicking your mouse.

OR

Press the TAB key until you see the box with a DOTTED outline. and then Press the SPACE bar to select or un-select the options.

Print Form

Iron Workers District Council of Southern Ohio & Vicinity Benefit Trust
1470 World Wide Place • Vandalia, OH 45377-1156
Phone (937) 454-1744 • Fax (937) 454-5457
Toll Free: (800) 331-4277

INSTRUCTIONS FOR FILING CLAIMS UNDER HEALTH REIMBURSEMENT ACCOUNT

Please read this before submitting your Claim Form Authorizing Payment of Premiums

Your claim is important, but in order for us to process it and provide you with your reimbursement quickly and fully, we need you to completely and accurately fill out and submit the attached HEALTH REIMBURSEMENT ACCOUNT CLAIM FORM. To help you, we have provided the following guidelines:

GENERAL RULES

- You will receive a notice of Self-Payment/ Retiree Plan Premium (if eligible) and COBRA continuation rights from the Benefit Trust Office.
- At this time, you will also receive a notice of your right to elect alternate coverage under the Self-payment Program or Retiree Plan instead of COBRA coverage.
- You must waive your COBRA coverage and elect the Self-Payment or Retiree Plan in order to have the option to spend down any existing HRA balance you have at the time your coverage under the Benefit Trust would have terminated.
- You have the option to spend down the HRA balance to pay the Self-Payment or Retiree Premiums to the Benefit Trust to maintain your eligibility.
- You cannot use the HRA to pay premiums to any other group health or individual insurance plan or to pay COBRA premiums.

You cannot receive a cash out or lump sum payment from this HRA. It is ONLY available for reimbursement of eligible medical expenses which you owe or already paid out of pocket OR to pay Self-Payment or Retiree Premiums to the Benefit Trust to maintain eligibility for yourself and your family.

TIPS FOR FILLING OUT YOUR CLAIM FORM

- Read through the whole Claim Form and provide all requested information pertaining to you and your claim for reimbursement.
- Provide the full name of the Participant and his/ her social security number and/or Health ID Number.
- The **Participant** is the only person authorized to file this Claim Form, so the **Participant** must sign the Claim Form. If you are a surviving spouse or surviving dependent who has a HRA due to the death of a Participant, you are eligible to file this Claim Form on your own behalf, if applicable.
- Once the Claim Form is properly completed, the premium payment will then be made from your HRA to the Benefit Trust directly.
- The Benefit Trust will NOT reimburse you directly for any premium or partial premiums you paid to maintain your eligibility. You must submit the authorization of payment to the Benefit Trust in advance of the premium due date in order to use your ARA balance to pay your premiums. The payment will ONLY be made from your HRA to the Benefit Trust directly.
- You must provide the total request amount at the bottom of the Claim Form. Please make sure that your reimbursement requests total at least $25.00, with the exception of the final balance remaining in the HRA, in which case the requested payment amount must be the entire balance.
- If you are requesting payment of your Self-Payment or Retiree Premium to this Benefit Trust, please submit the billing statement from the Benefit Trust as the receipt for this claim.

As always, if you have any questions regarding your HRA or filing of this claim for reimbursement, please contact the Benefit Trust Office.

OVER