EASTERN ATLANTIC STATES
CARPENTERS BENEFIT FUNDS
WWW.CARPENTERS.FUND

New Jersey Office: 91 Fieldcrest Ave. Suite A25, Edison, NJ 08837
(732) 417-3900

Philadelphia Office: 1811 Spring Garden St.
Philadelphia, PA 19130
(215) 568-0430

HRA Claim Form

Participant Name: _____ **UBC # or Last Four of SSN:** _____

HRA Qualified Health Care Expenses (Please complete and sign below.)

Timely filing for any claim is one year from the date services were rendered.

For each expense claimed (Medical, Dental, Orthodontic, Prescription, and Optical), submit a receipt or statement detailing the services provided, the name of patient, the date of service, diagnosis (if available), cost of service with proof of payment and an Explanation of Benefits (EOB) from any other insurance carrier or plan (if applicable). Expenses may only be submitted for you and your Eligible Family Members. Include a doctor's note when required.

- For Medical Insurance Premium Reimbursement: Submit pay stubs clearly showing deductions for medical premiums are after taxes. If it is not clearly stated on the paystub, a letter is required from the employer verifying they are **POST-TAX** deductions for health insurance benefits. The letter must include the medical premium cost to the employee, name of person the payment for health insurance is issued to, check date and company name.

Clearly legible photocopies of original receipts may be uploaded online at www.carpenters.fund

For information regarding eligible medical expenses, please refer to IRS Publication 502 (Medical Dental Expenses). WWW.IRS.GOV

Item No.	Date of Service	Name of Provider	Expense Description (Medical, Dental, Prescriptions)	Claim Amount
1				
2				
3				
4				
5				

Additional claim boxes located on the back of this form.

Total Amount Requested $

I acknowledge that the Plan shall pay or reimburse approved expenses from my account up to the account balance. I also certify that any eligible medical expenses submitted for reimbursement are for myself, my spouse, or Eligible Family Members and such expenses have not and will not be reimbursed under any other Health Savings Account, insurance plan or claimed as a deduction on a tax return or tax deductible Plan.

Participant Signature: _____ **Date:** _____

Upload your receipts fast and easy at www.carpenters.fund

Qualified Health Care Expenses (Please complete all applicable spaces)

Participant Name: _____ UBC # or Last Four of SSN:_____

Item No.	Date of Service	Name of Provider	Expense Description	Claim Amount
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
			TOTAL	$

Upload your receipts fast and easy at www.carpenters.fund