HRA Request for Reimbursement of Non-Recurring Expenses

ALL MEMBERS

Complete this form and send with supporting documentation to: **Zenith American Solutions, P.O. Box 1015, Minneapolis, MN 55440-1015.**

- Supporting documentation may consist of: Bills, Premium Notices, Explanation of Benefits, Receipts.
- A separate form must be completed for each eligible dependent.
- Each form of documentation must contain the date(s) of service, provider name, provider address, description of treatment, service or supply, as well as the name of the claimant.
- **PLEASE NOTE**: Do not submit claims for charges eligible for payment under your Insurance or Medicare. This includes all amounts available for reimbursement under Health FSAs unless you have exhausted the account balance. Do not submit claims after twelve (12) months from when you received the medical service or March 31, following the close of the Plan Year in which the Medical Care Expense was incurred. Do not submit claims for services prior to your benefit eligibility date.

PARTICIPANT INFORMATION – MUST BE COMPLETED (Please Print)

Plan Name: **MINNESOTA AND NORTH DAKOTA BRICKLAYERS AND ALLIED CRAFTWORKERS HRA**

Participant's Full Name (Last, First, Middle Initial) _____	**Participant's Social Security Number:** _____ **Gender:** ☐ Male ☐ Female **Marital Status:** ☐ Married ☐ Single **Date of Birth:** _____
Address: _____ _____ **Is this address a change**? _____ Yes _____No	**Home Phones:** _____ **Work Phones:** _____

Claim is for: ☐ **Self** ☐ **Spouse** ☐**Dependent Child** ☐**Other Dependent** ☐**Non-Spouse or Non-Dependent Beneficiary**

Claimant's Full Name (Last, First, Middle Initial) _____	**Claimant's Social Security Number:** _____

COVERAGE INFORMATION – MUST BE COMPLETED (Please Check a Box)

Was the Participant enrolled in employer sponsored group health plan coverage that provides minimum value* when claim was incurred?
☐ **Yes** ☐ **No** ☐ **Participant Retired** **If Yes, MUST sign below**

I attest that I am enrolled in employer sponsored group health plan coverage that provides minimum value*:

Participant Signature: _____
***Contact your employer (or spouse's) if unsure whether coverage provides minimum value**

REQUEST FOR REIMBURSEMENT OF EXPENSES
SUMMARY OF HEALTHCARE EXPENSES

NOTE: IF THE PARTICIPANT IS NOT ENROLLED IN EMPLOYER SPONSORED GROUP HEALTH PLAN COVERAGE THAT PROVIDES MINIMUM VALUE, THE ONLY CLAIMS ELIGIBLE FOR REIMBURSEMENT ARE EXCEPTED BENEFITS. EXPENSES SUBMITTED FOR A NON-EXCEPTED BENEFIT BY A PARTICIPANT WHO IS NOT ENROLLED IN EMPLOYER SPONSORED GROUP HEALTH PLAN COVERAGE WILL NOT BE REIMBURSED.

Incurred Date*	Provider (Doctor, Pharmacy Name)	Description of Claim	Amount to be Reimbursed

***Incurred date is the date the service was rendered, not the billing or payment date.**

The undersigned certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred by the participant, the participants spouse, the participants eligible dependents, or a designated beneficiary (after the participants death only) while the undersigned was eligible to receive benefits under the HRA Plan. The undersigned certifies as follows:

1. The medical expenses have not been reimbursed and are not reimbursable under any other health plan, dental plan, or Medicare.
2. The undersigned acknowledges that all amounts available for reimbursement under Health FSAs have been exhausted.
3. Nonprescription medications for which reimbursement is requested were purchased to alleviate or treat personal injuries or sickness.
4. The undersigned understands that she/he alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim.
5. The undersigned understands that she/he will be liable for payment of all related taxes including Federal, State, or local income tax on amounts paid from the plan for non-qualifying expenses

Member's Signature: _____ **Dated:** _____

See Other Side For: Reimbursement of Recurring Expenses-Retirees Only