Auxiant™
Your Integrated Benefits Partner

IBEW LOCAL 405
Health Reimbursement Arrangement (HRA) Claim Form

Name: _____ Date of Birth: _____ SSN: _____

Address: _____
Street / P.O. Box City State Zip

SUBMISSION DATE: _____ □ **Check Here if you are a Retiree**

A. MEDICAL EXPENSE REIMBURSEMENT REQUEST

Attach Explanation of Benefits (EOB) for each item *

Date of Service	Payment Made To:	Service Provided	Amount
			$
		Total Expenses:	$

***An Explanation of Benefits (EOB) form must be attached. If you have prescriptions, then you may submit a receipt. Otherwise, an EOB must be submitted or your claim will be denied. You are responsible for payment of expenses submitted for reimbursement. Please refer to the list of accepted expenses, or call Auxiant with any questions.**

B. SPOUSE AND DEPENDENT INFORMATION [c] (Please complete this section if any claims are for a spouse or dependent.)

_____
Name Date of Birth Relationship

_____
Name Date of Birth Relationship

[c] *Your spouse is the person to whom you were married at the end of the Calendar year. Your dependent is your child, stepchild, parent, other close relative, or a person who lives in your home, and for whom you provide over half of his/her support.*

C. SIGNATURE *

I certify that the expenses listed above qualify under sec. 213 of the Internal Revenue Code for reimbursement and have been incurred by eligible members of my family. I understand I am responsible for payment of expenses not covered by the health benefit plan and for which I am seeking reimbursement. These expenses have not been reimbursed by my health care plan or any other health care plan such as my spouse's. EOBs, receipts, or other evidence of these expenses are attached.

Signature _____ Date _____

Submit claim form to:
Auxiant • Attn: Vanessa Taylor • P.O. Box 75008 • Cedar Rapids, IA • 52407-5008
800-475-2232, 6, ext. 1221 • (Fax) 319-866-6234 • vtaylor@auxiant.com

* Please note your claim request will be denied without a signature and date.