UNITED STEELWORKERS
USW HRA FUND

Recurring Claim Form

For use in requesting a series of insurance premium payments

If Faxing,
# of Pages:

PARTICIPANT INFORMATION (Please print)

Name: _____ SSN: xxx-xx-_____

Address: _____ Email: _____

City, State Zip: _____ Day Phone: _____

Recurring Payment Information (Attach supporting documentation)					
Name of Insurance Company	Dates	Description of Insurance	Periodic Amount	# of Months to Pay (Maximum 12)	Total
			Total to be reimbursed		

- **Recurring claims must be re-filed each year in order to continue receiving reimbursement.**
- **Supporting documentation showing your premium amount must be included with this claim.**
- **Checks for insurance premiums sent to your insurance carrier will be sent by First-Class Mail from the Fund Office on the first pay date of each coverage month (HRA Payment Dates Calendar). The Fund Office DOES NOT guarantee a specific delivery date. Please consider these timing issues when making your selections below.**

Recurring Payment Instructions			
Send Payment to:	Me ☐	Insurance Company ☐	**Complete notary section if requesting payment to insurance company.**
Complete the following only if requesting payment to the insurance company:			
		Payment Frequency:	Monthly ☐ Quarterly ☐
Begin payment on (date):			
Amount of Payment:		Mail to (address):	
Policy Number:			
Make payable to:			

NOTARY SECTION *(To be completed only if authorizing payment directly to insurance company)*

Must be completed by a Notary Public and stamped with his or her official seal. Seal must be visible when faxing.

State of_____County of _____
On the_____day of_____, 20____before me
came_____, who executed the foregoing
instrument and duly acknowledged to me that he/she executed the same.

Affix Notary Seal Here

My Commission Expires:_____

PARTICIPANT CERTIFICATION – *PLEASE READ CAREFULLY*

The above is a true and accurate statement of all expenses incurred by my eligible dependents or me on the date(s) indicated and were incurred while I was covered under the USW HRA Fund. I attest that I and my eligible dependents, as applicable, are enrolled in other group health plan coverage that provides minimum value as defined under the Affordable Care Act. Supporting documentation from my service provider(s) for all expenses is attached to this claim form. I understand that I cannot claim any reimbursed medical expenses on my income tax return and that I may be liable for payment of all related taxes, including Federal, State or City income tax, on the amounts paid for any expense improperly claimed under the provision of the USW HRA Fund. I acknowledge that I have read and understand the additional participant certification included in the *Important Claims Submission Information Page*, and I agree to such certifications contained therein.

_____ _____

Participant Signature ***Date***

Mail To: USW HRA Fund
1101 Kermit Drive, Ste 800
Nashville, TN 37217

Fax To: (615) 333-5797
Email To: *hra@uswbenefitfunds.com*
Phone: 800-251-4107, select option 2

USW HRA Fund
Important Claims Submission Information
Please DO NOT Fax or Mail This Page

Definition of "Incurred"

The term "incurred" used throughout this form refers to the date you or your eligible dependent is provided the care that gives rise to the medical, dental, vision, prescription, or other qualifying expense. This date could be different than the date you are billed or pay for the expense.

Additional Participant Certification

I certify the expenses for which I am claiming:

- **Were incurred by me or my eligible dependents (spouse is considered a dependent) during a plan year in which I and/or my dependent(s) were covered under this Plan.**
- **If over-the-counter medication or drugs, were incurred solely to alleviate or treat personal injury or sickness.**
- **Will not be claimed as a deduction or credit on any personal income tax return.**
- **Are eligible according to the terms of the Plan. If I've received a reimbursement for expenses later found ineligible, I must return the reimbursement to the Fund, or I will be responsible for taxes or penalties arising from the ineligible expenses.**
- **I understand that USW HRA Fund may scan my claim and expense documentation and store them as digital images. My original claim and expense documentation may be destroyed by USW HRA Fund within a reasonable time period after receipt.**
- **If I am also a participant in a Section 125 Health Care Flexible Spending Account Plan ("FSA"), I certify that I have exhausted all my benefits under the FSA prior to filing this claim.**
- **I certify I was not reimbursed and this claim is not reimbursable under any other medical plan that provides the Participant or Dependent with health coverage.**

Faxing and Mailing Tips

To receive the fastest possible reimbursement, email your claim online to hra@uswbenefitfunds.com. If you do not have internet access you can submit your claim by using our fax line. You can also mail your claim; however, you may experience slower reimbursements due to mailing delays. Faxed or mailed claims require up to seven business days for review.

Please do not use a highlighter on this form or claim documentation. Instead, circle and add notations with a dark pen.

Fax and Scanning Tips

- **Complete claim form using a dark pen (do not use pencil).**
- **If your documentation is printed on dark paper, copy it onto lighter paper.**

Mailing Tips

- **Do not mail originals.**
- **Do not staple**
- **Neatly tape any small receipts onto a 8½ by 11" piece of paper**

Fax or mailed claims may not be verified until up to seven business days after receipt.

Helpful Hints on How to Successfully File a Claim

- **Documentation must clearly list the date the service was incurred, provider name, type of service, patient name, and your portion of the service provided.**
- **If the expense incurred is reimbursable by an insurance company, you must submit the expense to the insurance company FIRST. You can then use the Explanation of Benefits (EOB) received from the insurance company as your expense documentation. The EOB you receive from your insurance company is the best source of expense documentation for use in submitting your claims.**
- **Canceled checks, 'balance forward' statements, 'previous balance' statements, 'paid on account' statements or receipts, charge card receipts, or charge card statements are not acceptable forms of expense documentation according to the IRS as they do not clearly indicate the date or type of service.**
- **For prescription expenses, submit the prescription receipt you received with the medication purchased showing the patient name, medication name, the date the prescription was filled, and the amount you owe for the medication. Cash register receipts or charge slips for prescription purchases cannot be accepted as they do not indicate the medication name or patient.**
- **For over-the counter medications for which you have a prescription, submit an original cash register receipt that clearly indicates the item name (such as cold medicine, antacid, allergy medicine, or pain reliever), date, and cost of the item purchased. According to the IRS, handwriting the required information on the receipt or attaching box tops or other product information to the receipt is NOT acceptable. Insufficiently documented claims are not eligible for reimbursement.**
- **All expenses must be incurred prior to being considered for reimbursement. If the expense has not been incurred, it is not eligible for reimbursement.**
- **Keep copies of your claim. You can submit *legible* photocopies of your expense documentation.**

Definitions

Dates of Service – **The date the service was incurred. This date could be different than the date you are billed or the date you pay for the expense. Prescription drugs are based on the date the prescription is filled and eyeglass/contact lens purchases are based on the date ordered. These dates could be different than the date picked up or the date paid.**

Provider Name / Type of Service – **Doctor name, store name, dentist, clinic, hospital, etc. along with what service was performed (for example, 'Dr. Smith/Office visit', ABC Drug Store / Prescriptions,' or 'The Vision Store / Contacts').**