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 INFORMAT				
PARTICIPANT INFURIMA	PION MUST DE CON	ADI ETED (Dlagge	Duint)	
			LIED CRAFTWORKERS HRA	
Participant's Full Name (Last, F	irst, Middle Initial)	Condon	Participant's Social Security Number: Gender: □ Male □ Female Marital Status: □ Married □ Single	
			Date of Birth:	
		Date of Bi	iui	
Address:		Home Pho	Home Phones:	
T. d		Work Pho	nes:	
Is this address a change?	_ YesNo	Other Dependent	Non-Spouse or Non-Dependent Beneficiary	
Claim is for: \square Sen \square Spouse	□Dependent Child □	Other Dependent L	inton-spouse of Non-Dependent Beneficiary	
Claimant's Full Name (Last, Fir	st, Middle Initial)	Claimant's Soci	al Security Number:	
COVERAGE INFORMATIO	N MUST DE COMDI	ETED (Dlagge Char	alt a Day)	
COVERAGE INFORMATIO	N – MIUST DE COMPL	ETED (Please Che	ck a dox)	
Was the Participant envelled in	omnloven enencened eneur	hoolth plan governor	that provides minimum value* when alaim was incurred?	
		neann pian coverage <u>MUST</u> sign below	that provides minimum value* when claim was incurred?	
	punt Retired II 1 cs,	sign below		
I attest that I am enrolled in emp	oloyer sponsored group he	alth plan coverage th	at provides minimum value*:	
		•	•	
Participant Signature:				
*Contact your employer (or spo				
			NT OF EXPENSES	
	SUMMARY	OF HEALTHCAL	RE EXPENSES	
			PONSORED GROUP HEALTH PLAN COVERAGE THAT E FOR REIMBURSEMENT ARE EXCEPTED BENEFITS	
			BY A PARTICIPANT WHO IS NOT ENROLLED IN	
			WILL NOT BE REIMBURSED.	
I	Provider (Doctor,			
Incurred Date*		Description of	Amount to be Reimbursed	
1110011100 2 000	Pharmacy Name)	Description of Claim	Amount to be Reimbursed	
2110012700 2 000			Amount to be Reimbursed	
23003700 2 000			Amount to be Reimbursed	
23001700 2000			Amount to be Reimbursed	
	Pharmacy Name)	Claim		
*Incurred date is the date the s	Pharmacy Name) ervice was rendered, not t	Claim he billing or payment	date.	
*Incurred date is the date the s The undersigned certifies that all	Pharmacy Name) ervice was rendered, not t expenses for which reimbu	Claim he billing or payment is	date. claimed by submission of this form were incurred by the	
*Incurred date is the date the s The undersigned certifies that all participant, the participants spou	Pharmacy Name) ervice was rendered, not t expenses for which reimbu se, the participants eligible of	he billing or payment is dependents, or a design	date. claimed by submission of this form were incurred by the ated beneficiary (after the participants death only) while the	
*Incurred date is the date the s The undersigned certifies that all participant, the participants spou undersigned was eligible to recei	Pharmacy Name) ervice was rendered, not to expenses for which reimbut se, the participants eligible down benefits under the HRA	he billing or payment resement or payment is dependents, or a design Plan. The undersigned	date. claimed by submission of this form were incurred by the ated beneficiary (after the participants death only) while the certifies as follows:	
*Incurred date is the date the s The undersigned certifies that all participant, the participants spou undersigned was eligible to recei 1. The medical expenses have	ervice was rendered, not to expenses for which reimbut se, the participants eligible over benefits under the HRA into the been reimbursed and are	he billing or payment resement or payment is dependents, or a design Plan. The undersigned e not reimbursable under	date. claimed by submission of this form were incurred by the ated beneficiary (after the participants death only) while the certifies as follows: er any other health plan, dental plan, or Medicare.	
*Incurred date is the date the s The undersigned certifies that all participant, the participants spou undersigned was eligible to recei 1. The medical expenses have 2. The undersigned acknowled	ervice was rendered, not to expenses for which reimbut se, the participants eligible to the benefits under the HRA into the benefits under the HRA into the the that all amounts available.	he billing or payment resement or payment is dependents, or a design Plan. The undersigned e not reimbursable under the for reimbursable under the formal reimb	date. claimed by submission of this form were incurred by the ated beneficiary (after the participants death only) while the certifies as follows: er any other health plan, dental plan, or Medicare. nder Health FSAs have been exhausted.	
*Incurred date is the date the s The undersigned certifies that all participant, the participants spou undersigned was eligible to recei 1. The medical expenses have 2. The undersigned acknowled 3. Nonprescription medication	ervice was rendered, not to expenses for which reimburse, the participants eligible to the benefits under the HRA into the been reimbursed and are ges that all amounts availables for which reimbursement in	he billing or payment is rement or payment is dependents, or a design Plan. The undersigned e not reimbursable under the for reimbursable under the for reimbursement us requested were purch	date. claimed by submission of this form were incurred by the ated beneficiary (after the participants death only) while the certifies as follows: er any other health plan, dental plan, or Medicare. nder Health FSAs have been exhausted. nased to alleviate or treat personal injuries or sickness.	
*Incurred date is the date the s The undersigned certifies that all participant, the participants spou undersigned was eligible to recei 1. The medical expenses have 2. The undersigned acknowled 3. Nonprescription medication 4. The undersigned understand	ervice was rendered, not to expenses for which reimburse, the participants eligible to the benefits under the HRA into the been reimbursed and are ges that all amounts availables for which reimbursement in	he billing or payment is rement or payment is dependents, or a design Plan. The undersigned e not reimbursable under the for reimbursable under the for reimbursement us requested were purch	date. claimed by submission of this form were incurred by the ated beneficiary (after the participants death only) while the certifies as follows: er any other health plan, dental plan, or Medicare. nder Health FSAs have been exhausted.	
*Incurred date is the date the s The undersigned certifies that all participant, the participants spou undersigned was eligible to recei 1. The medical expenses have 2. The undersigned acknowled 3. Nonprescription medication 4. The undersigned understand claim.	ervice was rendered, not to expenses for which reimbuse, the participants eligible over benefits under the HRA into been reimbursed and are ges that all amounts availables for which reimbursement is that she/he alone is fully respectively.	he billing or payment is dependents, or a design Plan. The undersigned enot reimbursable under the for reimbursable under the for reimbursement us requested were purchesponsible for the suffice.	date. claimed by submission of this form were incurred by the ated beneficiary (after the participants death only) while the certifies as follows: er any other health plan, dental plan, or Medicare. nder Health FSAs have been exhausted. nased to alleviate or treat personal injuries or sickness. ciency, accuracy, and veracity of all information relating to this	
*Incurred date is the date the s The undersigned certifies that all participant, the participants spou undersigned was eligible to recei 1. The medical expenses have 2. The undersigned acknowled 3. Nonprescription medication 4. The undersigned understand claim. 5. The undersigned understand	ervice was rendered, not to expenses for which reimbursed and are ges that all amounts availables for which reimbursement is that she/he alone is fully restricted.	he billing or payment is dependents, or a design Plan. The undersigned enot reimbursable under the for reimbursable under the for reimbursement us requested were purchesponsible for the suffice.	date. claimed by submission of this form were incurred by the ated beneficiary (after the participants death only) while the certifies as follows: er any other health plan, dental plan, or Medicare. nder Health FSAs have been exhausted. nased to alleviate or treat personal injuries or sickness.	
*Incurred date is the date the s The undersigned certifies that all participant, the participants spou undersigned was eligible to recei 1. The medical expenses have 2. The undersigned acknowled 3. Nonprescription medication 4. The undersigned understand claim.	ervice was rendered, not to expenses for which reimbursed and are ges that all amounts availables for which reimbursement is that she/he alone is fully restricted.	he billing or payment is dependents, or a design Plan. The undersigned enot reimbursable under the for reimbursable under the for reimbursement us requested were purchesponsible for the suffice.	date. claimed by submission of this form were incurred by the ated beneficiary (after the participants death only) while the certifies as follows: er any other health plan, dental plan, or Medicare. nder Health FSAs have been exhausted. nased to alleviate or treat personal injuries or sickness. ciency, accuracy, and veracity of all information relating to this	
*Incurred date is the date the second of the undersigned certifies that all participant, the participants spou undersigned was eligible to receing the undersigned acknowled as the undersigned acknowled as the undersigned understand claim. 5. The undersigned understand paid from the plan for non-order than the undersigned understand paid from the plan for non-order than the undersigned understand paid from the plan for non-order than the undersigned understand paid from the plan for non-order than the undersigned understand paid from the plan for non-order than the undersigned understand paid from the plan for non-order than the undersigned understand paid from the plan for non-order than the undersigned understand the undersigned the undersigned understand the undersigned the undersig	ervice was rendered, not to expenses for which reimbursed and are used to the expenses for which reimbursed and are used to the end of the expenses for which reimbursed and are used to the end of th	he billing or payment resement or payment is dependents, or a design Plan. The undersigned e not reimbursable under the for reimbursement us requested were purch esponsible for the sufficor payment of all related	date. claimed by submission of this form were incurred by the ated beneficiary (after the participants death only) while the certifies as follows: er any other health plan, dental plan, or Medicare. nder Health FSAs have been exhausted. hased to alleviate or treat personal injuries or sickness. ciency, accuracy, and veracity of all information relating to this ed taxes including Federal, State, or local income tax on amounts	
*Incurred date is the date the s The undersigned certifies that all participant, the participants spou undersigned was eligible to recei 1. The medical expenses have 2. The undersigned acknowled 3. Nonprescription medication 4. The undersigned understand claim. 5. The undersigned understand	ervice was rendered, not to expenses for which reimbursed and are used to the expenses for which reimbursed and are used to the end of the expenses for which reimbursed and are used to the end of th	he billing or payment resement or payment is dependents, or a design Plan. The undersigned e not reimbursable under the for reimbursement us requested were purch esponsible for the sufficor payment of all related	date. claimed by submission of this form were incurred by the ated beneficiary (after the participants death only) while the certifies as follows: er any other health plan, dental plan, or Medicare. nder Health FSAs have been exhausted. nased to alleviate or treat personal injuries or sickness. ciency, accuracy, and veracity of all information relating to this	