

Participant's Name (last, first, middle initial)

Mailing Address

SMART LOCAL 36 HRA CLAIM FORM 2319 CHOUTEAU AVE., SUITE 300 SAINT LOUIS, MO 63103 phone 314-652-8175 fax 314-652-0338

Date

Social Security Number

## RETIREE HRA PREMIUM REIMBURSEMENT CLAIM FORM

**Participant Information** 

Date of Birth

City		State	Zip Phone Number
QUALIFIED PREMIUM REIMBURSEMENT EXPENSES			
Item	Member Name	Premium Month/Year	Requested Amount
1			\$
2			\$
3			\$
4			\$
5			\$
6			\$
7			\$
8			\$
9			\$
10			\$
11			\$
4.0			4

I acknowledge that the Plan Administrator shall pay or reimburse approved expenses from the appropriate account up to the account balance. I certify that the dependents for whom I am submitting claims are eligible dependents according the Section 152(a) of the IRS Code and as described in IRS Publication 502. I also certify that any expenses reimbursed are for eligible premiums for myself, my spouse, or eligible dependents 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.