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

RETIREE HRA PREMIUM REIMBURSEMENT CLAIM FORM

Participant Information			
Participant's Name (last, first, middle initial)		Date of Birth	Social Security Number
Mailing Address			
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		___/_______	$
12		___/_______	$

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.

Signature	Date