UA Local 190 Health and Welfare Plan
Health Reimbursement Account Request

Instructions

- You must Complete Section A, select the option under Section B that you requesting, and sign and date Section D.
- Complete Section C if you are requesting reimbursement of claim expenses under Section B, option 2.
- NOTE: You must complete this form each time you request a one-time Health Care Self Pay or reimbursement of expense from your IHRA.

A. Employee Information

Last four digits of Social Security # XXX-XX ___ ___ ___ ___	Last Name	First Name
Address	City	State/Zip
Phone #	E-Mail Address	

B. Options

1. ☐ ***SELF PAYMENT*** - I elect to have my monthly Health Care Pay taken from my IHRA account for the eligibility month of________________________________, in the amount of $_____________________.

2. ☐ ***REIMBURSEMENT*** - I request reimbursement of Health Care Expenses listed in Section C from my IHRA account.

C. Health Care Expenses

Patient Name	Provider Name	Dates of Service	Total Claim Charge	Total Insurance Paid	Total IHRA Request Amount
	TOTALS				

D. Certification

I hereby request payment of my monthly Health Care Self Pay as requested under Section B, Option 1 and/or request reimbursement of Health Care Expenses listed under Section C.

Employee Signature *(Required)*	Date

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