HOSPITALITY PLAN
UNITE HERE HEALTH

Health Reimbursement Arrangement (HRA) Claim Form

STEP ONE: PARTICIPANT INFORMATION

Last Name:	First Name:	M.I.	Phone Number:
Mailing Address:			Participant's Alternate ID or Social Security Number:
			_____

STEP TWO: HEALTH REIMBURSEMENT ACCOUNT (HRA) INFORMATION

In order to receive reimbursement, please complete the following in full, and attach a copy of the Explanation of Benefits (EOB) or itemized statements that show the uncovered health care expenses and the reason why the claim was not paid or not paid in full. For prescription drug claims, you must provide a copy of the prescription receipt showing the patient's name, date of service, type of prescription, and co-payment amount.

Patient's Name	Age	Relationship to Participant	Dates of Service	Type of Service (Med/Den/Rx)	Amount of Requested Reimbursement*
					$
					$
					$
					$
					$
*You must calculate the amount you wish to claim from your HRA account. We cannot process your reimbursement request without this information.				Total:	$_____

If you have more claims to submit than what is listed above, you are required to complete another claim form.

STEP THREE: PARTICIPANT CERTIFICATION AND SIGNATURE

I request reimbursement for the eligible expenses listed above. I certify that the above information is correct and that I have not received reimbursement for these expenses from this HRA account and have not, and will not, receive reimbursement for these expenses from any other plan. I understand that expenses reimbursed under this Health Reimbursement Account (HRA) cannot be used to claim a deduction or tax credit on my personal income tax.

_____ _____

Participant's Signature Date

CLAIM INSTRUCTIONS

- Complete all sections of this form.
- Attach the following documents:
  - ✓ The Explanation of Benefits form (EOB) issued by an insurance company that shows uncovered health care expenses and the reason why the claim was not paid or not paid in full.
  - ✓ If an EOB is not provided, include itemized bills which include the patient's name, provider name, date of service, type of service, and any plan payments.
  - ✓ Cancelled checks or register receipts alone cannot be accepted as documentation
  - ✓ Please retain a copy of this form and all documentation for your records. Originals will not be returned.

Mail completed form and original documentation to:

UNITE HERE Hospitality HRA
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1-855-405-3863

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Email flex@zenith-american.com