

**ELECTRICAL WORKERS BENEFIT TRUST FUND
HEALTH REIMBURSEMENT ACCOUNT CLAIM
FORM**

Employee / Patient Information: Complete a separate form for each dependent.

Employee Name: _____ SSN# _____

Address: _____ Phone # _____

Patient: _____ Relationship to Employee: _____

Expense Detail: Complete the table below including the date of service or purchase date, a short description and cost of each item. **A copy of the ITEMIZED bill and Proof of Payment must accompany all claims.** Submit the completed form, along with receipts, to:

Electrical Workers Benefit Trust Fund
1828 North Meridian, Suite 103
Indianapolis, IN 46202

Date of Service or Purchase	Description	Amount

Total

I understand reimbursement for the above claims will be deducted from my Health Reimbursement Account (Account) as long as there are available funds in my Account. If the total amount is not available, I authorize a partial reimbursement and understand I cannot re-submit these claims at any time for any unpaid balance.

Employee's signature

Date

For questions, please contact the Fund Office at (317) 923-4577.

For more details regarding eligible expenses, please refer to IRS Publication 502 which is available on the Internet at:
<http://www.irs.gov/pub/irs-pdf/p502.pdf>.