PSSU LOCAL UNIT HEALTH AND WELFARE FUND

Health Reimbursement Arrangement (HRA) Claim Form

County of Bucks Retiree Name: _____

Participant SS Number: _____

Telephone: _____ E-mail: _____

Please complete this claim form. Incomplete forms will be returned to you. To expedite your claim, please list receipts by month they are incurred. Feel free to copy this blank form.

Date Expense Incurred	Name of Service Provider	Expense Description (Rx, co-pay, deductible, etc.)	Person for Whom Expense Incurred	Net Amount

Read Carefully: By signing below, I certify the following: 1) The expense(s) for which reimbursement is requested were provided while I was covered under the Plan. 2) The health care expenses have not been reimbursed from any other source, nor will reimbursement be sought from any other source. 3) All information provided above is complete and accurate . 4) Unless an expense is a qualifying expense under the Plan, I will be required to repay an amount equal to such erroneous reimbursements. 5) Failure to provide complete and accurate information regarding qualifying expenses only may result in adverse tax consequences.

Please Note: Your Health Reimbursement Arrangement (HRA) Plan may limit the types of healthcare expenses that may be reimbursed to you. Please read the Summary Plan Description for your HRA Plan, for a list of eligible expenses.

_____ _____

Retiree Signature Date

Mail the claim form and copies of your receipts to:
PSSU Local Unit Health and Welfare Fund
2589 Interstate Drive
Harrisburg, PA 17110

This form can be downloaded from: http://pssuhwfund.org