PSSU Local Unit Health & Welfare Fund
Health Reimbursement Arrangement (HRA) Claim Form

Retiree Name: ____ SS Number: __________________________

Address: ____

City: _________________________________ State: ____________________ Zip Code: ________________

Telephone: ______________________________ Email: ____

Please complete this claim form as incomplete forms will be returned to you. To expedite your claim form, please list receipts by the date they were incurred. Feel free to copy this blank form for future claims. **Please submit claims on a monthly basis. All claims must be submitted by March 31st of the following year. For example, claims for 2019 must be submitted by March 31, 2020.**

Date Expense Incurred	Name of Service Provider	Expense Description (Rx, co-pay, deductible, etc.)	Person for Whom Expense Incurred	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 this claim form and copies of your receipts to:
PSSU Local Health & Welfare Fund, 2589 Interstate Drive, Harrisburg, PA 17110

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