UPPER PENINSULA PLUMBERS' & PIPEFITTERS' HEALTH & WELFARE FUND

Return completed form to:
P.O. Box 91082, Seattle, WA 98111
Fax # 1-866-528-7722

MEDICAL REIMBURSEMENT ACCOUNT (MRA) CLAIM FORM

NOTE: IF YOU HAVEN'T ACTIVATED YOUR DEBIT CARD, PLEASE DO SO TODAY. IF YOU NEED ASSISTANCE, PLEASE CALL US AT 1-866-823-4730

Name: (Please Print)		**Date of Birth:**	
Address:	**City:**	**State:**	**Zip:**
Member ID or SSN #:	**Local Union #:**		
Enclosed claims are for: ☐ **Member** ☐ **Spouse** ☐ **Son** ☐ **Daughter**			
Dependent's Name	**Dependent's Date of Birth**		

Reimbursement Request

For each reimbursement request, you must submit the following:

Explanation of benefits (EOB) for each medical/dental/vision expense submitted

For prescription drug reimbursement requests, you must submit an itemized receipt or printout from the pharmacy

If there is not enough in your account to cover the full amount requested, a check will be issued for the balance of your MRA account.

Total amount submitted from EOB's:	**$**
Total amount submitted from Prescription receipts:	**$**
Total amount submitted from self-payments:	**$**
Total amount submitted from self-payments:	**$**

The undersigned certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred by the participant, the participants spouse, the participants eligible dependents, or a designated beneficiary (after the participants death only) while the undersigned was eligible to receive benefits under the MRA Plan. The undersigned certifies as follows:

1. The medical expenses have not been reimbursed and are not reimbursable under any other health plan, dental plan, or Medicare.
2. The undersigned acknowledges that all amounts available for reimbursement under Health FSAs have been exhausted.
3. Nonprescription medications for which reimbursement is requested were purchased to alleviate or treat personal injuries or sickness.
4. The undersigned understands that she/he alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim.
5. The undersigned understands that she/he will be liable for payment of all related taxes including Federal, State, or local income tax on amounts paid from the plan for non-qualifying expenses

I hereby certify that the expenses for which I am requesting reimbursement have been paid in full.

Signature: _____ **Dated:** _____

Telephone Number (including area code):

Return this completed reimbursement request to the address above.

Non-Eligible Over-the-Counter Medical Expenses

Vitamin (for the general health of an individual)
Toiletries, such as toothpaste, mouthwash, etc.
Dietary and Nutritional Supplements
Cosmetics, such as face cream, etc.

Examples of Non-Eligible Health Care Expenses

Any illegal treatment	Diaper service
Cosmetic services and procedures (unless necessary to restore normal functioning)	Health and beauty aids
Food for weight loss programs	Karate or Kick boxing classes
Medications specifically used for cosmetic purposes	Over-the-counter drugs (including health & beauty aids, vitamins, and nutritional supplements) for general well-being.
Cost of remedial reading classes for non-disabled child	Teeth Whitening
Dancing or ballet, even when recommended by doctor	Funeral Expenses
Hospital benefits tax withheld from your pay as part of the Social Security tax or paid as part of Social Security self-employment tax	Nursing Care for a healthy baby
Travel your doctor told you to take for a rest or change	