North Atlantic States Carpenters
Health Benefits Fund

Long Island Office
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Hauppauge, NY 11788-5150
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Fax: (631) 952-9813
www.carpentersfund.org

Application for Health Reimbursement Account Withdrawal
Long Island, Westchester, Hudson Valley, Albany

(Please complete the area below and sign at the bottom)

______________________________________ ____________________________
Member's Name Social Security Number

______________________________________ ____________________________
Address City, State, Zip Local Number

______________________ ______________________ $____________________
Telephone Number Email Amount Requested

Check type of Non-taxable Benefits applied to: **You May Choose More Than One Expense**

_______ **MEDICAL REIMBURSEMENT** ________ **PRESCRIPTION**

_______ **DENTAL EXPENSES** _______ **OPTICAL EXPENSES**

**** You cannot use your Health Reimbursement Account in lieu of medical insurance. ****

- Submit **detailed bills and/or corresponding Explanation of Benefits (EOB) from Insurance along with an original receipt or a clearly legible photocopy showing payment**. All detailed bills must show dates of services, name of patient, diagnosis (if available), cost of service with proof of payment and explanation of benefits from any other insurance carrier or plan.
- **Expenses may only be submitted for self, legal spouse, or dependents. An HRA Enrollment form must be submitted annually.**
- **If you are not covered with the North Atlantic States Carpenters Health insurance – an Attestation form MUST be submitted and on file annually in order for your account to be accessible.**
- **Claims must total a minimum of $100.00 (except for claims submitted in January and/or July)**
- **You are limited to one submission of claims for each calendar month.**

_____ **MEDICAL INSURANCE PREMIUM REIMBURSEMENT –** In order to be considered for reimbursement for your health insurance premiums, it must be an ACA credible group health plan provided by your employer or spouses employer on a post-taxed deducted basis.

(Please note that subsidized premiums purchased through the Marketplace are not reimbursable)

Submit pay stubs showing deductions for medical premiums are after taxes. If it is not clearly stated on the paystub, a letter is required from the employer verifying they are **POST-TAX** health insurance benefits. The letter must include the medical premiums cost to the employee, name of person check is issued to, check date and company name.

Timely filing for any claim is one year from the date services were incurred.

- **Administrative Fee -** If there have been no contributions to, or withdrawals from your Supplemental Health Reimbursement Account for 12 consecutive months the Fund will automatically deduct an annual administrative fee of $120.00 from your HRA.
- **Forfeiture –** Any balance in your Supplemental Health Reimbursement Account will be forfeited following 36 consecutive months of no activity. (no activity means no Employer contributions have been made to your account and no amounts have been deducted from your account)

FRAUD WARNING: ***Any person who knowingly files a claim containing false information is subject to criminal and civil penalties. I hereby certify that the paid expenses submitted are for myself, my legal spouse, or my legal dependents and we are not covered under any other insurance policy that has not been declared.***

Member's Signature________________________________ **Date** ______________

PROPERLY SUBMITTED PAPERWORK WILL BE PROCESSED WITHIN 30 DAYS