UA Local 190 Health and Welfare Plan
Individual Health Reimbursement Account Request

Instructions

- **You must Complete Section B and select the reimbursement option under Section A and sign and date Section D.**
- **Complete Section C if you are requesting reimbursement of claim expenses under Section A, options 2 and/or 3.**
- **NOTE: You must complete this form each time you request payment of a self-payment or reimbursement of expense from your IHRA. Payment and Reimbursement will not happen automatically.**

A. Reimbursement Options

1. _____ I elect to make my Health self-payment from my IHRA for the eligibility month of _____, in the amount of $_____.

2. _____ I request reimbursement of Health Care Expenses listed in Section C that have been denied since my Miscellaneous Account was exhausted for the year.

3. _____ I request reimbursement of Health Care Expenses listed in Section C that are for medical expenses after retirement (for example, Medicare premiums)

B. Employee Information

Employee Social Security #	Last Name	First Name
Phone #	Address	City/State/Zip
E-Mail Address		

C. Health Care Expenses

Please be sure to provide a copy of your Plan EOB or receipt for each item listed below. If you would like to provide additional information concerning your claims please complete the back of this form.

Patient Name	Provider Name	Dates of Service	Total Charge	Amount Paid by Miscellanous Account	Amount To Be Reimbursed by IHRA Account
TOTALS					

D. Certification

I hereby request payment of my active or retiree self-payment as requested under section A, option 1 and/or request reimbursement of Health Care Expenses listed under Section C.

Employee Signature *(Required)*	Date

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Additional Information