IRON WORKERS'
Tri-State Welfare Fund

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Schaumburg, Illinois 60173
Toll-Free 844-395-4467
Fax 847-519-1979
www.tristatewelfarefund.com
tristateiron@groupadministrators.com

HEALTHY FOUNDATIONS ACCOUNT (HRA) REIMBURSEMENT REQUEST

NAME _____

SOCIAL SECURITY #_____ PHONE #_____

ADDRESS _____

PAYMENT REQUEST FOR SELF-PAYMENT

	AMOUNT	ELIGIBILITY QTR/MONTH(S)
REGULAR SELF-PAYMENT	$ _____	_____
COBRA PAYMENT	$ _____	_____

To make the entire self-pay from your HRA account, you may fax or email this form. If a check is included, please submit this form and your check to the address on your self-pay letter. For installment payments from your HRA, this form is required to be submitted for each installment payment.

PAYMENT REQUEST FOR REIMBURSABLE EXPENSE

EXPENSES (Describe type of expense)	AMOUNT
_____	$ _____
_____	$ _____
_____	$ _____
TOTAL	$ _____

For reimbursement of expenses, complete the information below for payment by direct deposit. You must include an itemized bill, proof of payment, and Explanation of Benefits.

Name of Financial Institution: _____ ☐ Checking ☐ Savings

Routing Number: ☐☐☐☐☐☐☐☐☐

Account Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Signature:_____ Date:_____