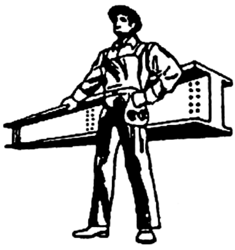

# IRON WORKERS' Tri-State Welfare Fund

20 N Martingale Road Suite 290
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 ______________________________

### REQUEST FOR SELF-PAYMENT

| | SELF-PAY AMOUNT | ELIGIBILITY QTR/MONTH(S) |
|---|---|---|
| REGULAR SELF-PAYMENT | $ ____________ | ____________ |
| COBRA PAYMENT | $ ____________ | ____________ |

For self-payments, complete sections above. If entire self-payment is being requested, you may fax or email. If a check is also included, submit this form and your check to the address indicated on your self-pay letter. For monthly installment payments, this form is required to be submitted for each payment.

### REQUEST FOR REIMBURSEMENT OF OOP EXPENSES

| 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:______________________