

Please type or **print** in black ink. You may fill in and print out this form online at [www.hraveba.org](http://www.hraveba.org)

**1. INSTRUCTIONS FOR FILING CLAIMS FOR BENEFITS**

- Please follow steps 1 – 5 below.  
 Please list only one person on each claim form. It is OK to use photocopies of this form, or you may print claim forms from our website at [www.hraveba.org](http://www.hraveba.org). Only claims for expenses or premiums incurred subsequent to participant's membership effective date may be submitted.
- Step 1.** Complete Section 2. (To speed processing, please answer all applicable questions.)
  - Step 2** Complete all of Sections 3 and/or 4, and Section 5.
  - Step 3.** Attach **itemized** verification for each expense or service item listed on this claim. You must provide either: an Explanation of Benefits (EOB); itemized billing or itemized statement from your provider; or a detailed receipt for prescription or over-the-counter medications.
  - Step 4.** Sign and date the back of the form in Section 6.
  - Step 5.** Mail, fax or e-mail this completed form and itemized claim verification to the third-party administrator (TPA). See reverse side for contact information.

**2. CLAIMANT**

Please print clearly.  Check here if this is a change of address.

Your Name: \_\_\_\_\_ SSN or Account No.: \_\_\_\_\_  
 (Plan Participant)

Home Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Employer: \_\_\_\_\_

Work Phone: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

**Complete if claim is for a spouse/dependent. This is a (check one):**  **Spouse Claim**  **Dependent Claim**

Name of spouse/dependent: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relationship to plan participant: \_\_\_\_\_

Eligible dependents are defined by Internal Revenue Code Section 105(b) and outlined in IRS Publication 501. Individuals can qualify as your dependent under this plan if they are a "qualifying child" or "qualifying relative" for the year in which the expense is incurred. A "qualifying child" is an individual who: lived with you for more than half the year and did not provide more than half of his/her own support; is under age 19 or age 24 (if a full-time student) on the last day of the current year; and is your child, step-child, sibling, step-sibling or a descendent of these individuals. A "qualifying relative" is an individual who receives more than half of his/her support from you, is not a qualifying child of yours or any other taxpayer and is a qualifying relative or any unrelated individual who shares your residence for the entire year as a member of your household.

**3. EXPENSES**

**If your claim includes qualified health care expenses you must complete this section.**

Please attach verification of your listed claims. You may summarize multiple dates of service in a similar category, such as prescriptions, but all the receipts must be attached. If you are a current participant in a Section 125 Health Care Flexible Spending Account (FSA), you must exhaust the FSA benefits before filing an eligible VEBA claim.

Date(s) of Service:	Provider of Service(s):	Description of Service(s) Rendered:	Total Out-of-Pocket:
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
Total out-of-pocket expenses to be reimbursed from your account:			\$ _____

If more space is needed, please attach an additional sheet of paper. For additional claim forms, it is OK to use photocopies of this form. You can also print forms from our website at [www.hraveba.org](http://www.hraveba.org) or call 1-800-VEBA101 (832-2101) or (509) 534-0600.

#### 4. PREMIUMS

If your claim includes qualified insurance premiums you must complete this section. Please attach verification of payment of premiums. If you are requesting reimbursement of long-term care premiums, you must attach verification of the premium amount and that the policy is tax-qualified. Long-term care premium reimbursements are also subject to annual IRS limits.

Name of Insurance Company	Premium Amount	List Months Paid	Total Paid
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____
Total premiums to be reimbursed from your account:			\$ _____

**Note: Premiums paid by an employer or through a pre-tax Section 125 Cafeteria Plan are not eligible for reimbursement.**

#### 5. SUMMARY

Total reimbursement for qualified health care expenses (from Section 3) and/or Total reimbursement for qualified insurance premiums (from Section 4)	\$ _____
Total to be reimbursed from your account: \$ _____	

#### 5. SIGNATURE

I hereby certify that the information provided in this claim request is true and correct and that the amount of this submitted claim to the HRA VEBA TPA is an accurate statement of my unreimbursed medical/dental/vision expenses and/or medical/dental/vision/tax-qualified long-term care insurance premiums, and that the submitted claim is not reimbursable from any other source. With respect to claims submitted on behalf of qualified dependents, I hereby certify that such person meets the Plan requirements as summarized above in Section 2 and is a qualified dependent as defined under the terms of the Plan.

\_\_\_\_\_  
Signature of Plan Participant

Signed this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

Please keep a copy of this form for your records. You may mail, fax or e-mail this form and claim verification to the TPA.

Third-Party Administrator  
REHN & ASSOCIATES  
P.O. Box 5433, Spokane, WA 99205-0433  
Fax: (509) 535-7883  
E-mail: [hraveba@rehnonline.com](mailto:hraveba@rehnonline.com)

Did you...

Complete ALL applicable sections?

Attach required verification for each section?

Sign this form?

The Trustees, TPA and your employer do not guarantee any tax results or particular tax treatment regarding the taxation of benefits provided by this Plan.

Qualified claims are any unreimbursed medical, dental or vision expenses defined by Internal Revenue Code Section 213(d) which are incurred by you, your spouse or qualified dependents. A list of qualified expenses may be viewed on our website. Qualified premiums include payments for medical, dental, vision or tax-qualified long-term care insurance.

If you have multiple investment funds, withdrawals from your account will be withdrawn pro-rata based on your fund allocation percentage currently on file with the TPA, unless you request otherwise.

If you have any questions about your account or a pending claim, or need claim forms, please visit [www.hraveba.org](http://www.hraveba.org), call the TPA toll-free at 1-800-VEBA101 (832-2101), or e-mail: [hraveba@rehnonline.com](mailto:hraveba@rehnonline.com).

**Please be sure to notify us in writing or via e-mail at [hraveba@rehnonline.com](mailto:hraveba@rehnonline.com) of any address change.**