International Union of Painters and Allied Trades
District Council No. 21
Welfare Fund

HRA
Health Care Reimbursement Account Claim Form

Please Mail, E-mail or Fax forms to:

DC21 Benefits Office
2980 Southampton Road
Philadelphia, PA 19154 Attn: HRA

Tel: (215) 934-5130
Fax: (215) 934-5418
E-mail: mtoll@dc21funds.org* (Must be in pdf. format)

Employee's Name: Last First Middle	**Employee's Social Security Number**
Dependent's Name: Last First Middle	**Dependent's Social Security Number**
Employee's Street Address:	**Employee's E-Mail:**
City, State, Zip:	**Employee's Phone Number:**

Please attach detailed Statement of services from providers with Paid Receipts.

Dates of Service From	To	Provider's Name	Description of Reimbursement Request	Requested Reimbursement Amount

Minimum $200.00 requirement with Paid Receipts. Receipts must be within 1 year of claim.

Must provide a copy of *Current Insurance Coverage* if no longer covered with DC21 Insurance Coverage.

(Please see reverse side for more space. Processing time is 2 weeks.)

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Claim Certification

I certify that Reimbursement Claim expenses have been incurred and paid by me, my spouse, or dependent(s), and have not or will not be reimbursed from any other source and have not or will not be used by me, my spouse or my dependent(s) as deductions in filing income returns.

Signature **Date**

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*** Must be in PDF Format to be accepted by e-mail.
Any other format (images, doc., files) will not be accepted.