



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

HRA
Health Care Reimbursement Account Claim Form

Claims can be sent to:

DC21 Benefits Office
2980 Southampton Road

Philadelphia, PA 19154 Attn: HRA

Tel: (215) 934-5130

Fax: (215) 934-5418

E-mail: dmcgee@dc21funds.org* (Must be in pdf. format)

****Disclaimer: Due to the contents of the HRA Documents received via e-mail IUPAT DC21 is not liable for any data security risks.**

Employee's Name:			Employee's Social Security Number										
Last	First	Middle	X	X	X	■	X	X	■				
Dependent's Name:			Dependent's Social Security Number										
Last	First	Middle	X	X	X	■	X	X	■				
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		Provider's Name	Description of Reimbursement Request	Requested Reimbursement Amount
From	To			

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
