



**Allied Benefit Systems, Inc.**  
208 S. LaSalle St. Suite 1300  
Chicago, IL 60604  
Tel 800-618-2694  
Fax 312-602-6280  
www.alliedbenefit.com

**HEALTH REIMBURSEMENT ACCOUNT  
REIMBURSEMENT REQUEST FORM**

Employer Name <b>Plumbers Local #93</b>		Group Number <b>B04155</b>	Identification Number
Employee's Last Name		First	M.I.
Street Address		City	State
Social Security No.		Telephone No.:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
<b>HRA Expenses</b>			
1. Deductible/Co-Pay		\$ _____	
2. Over the Counter Items		\$ _____	
2. Other Eligible expenses		\$ _____	
<b>TOTAL AMOUNT REQUESTED</b>		<b>\$ _____</b>	
Note: If your claim is for any expenses incurred by a dependent, you must provide:			
a. Dependent's Name:		_____	
b. Dependent's Relationship to You:		_____	
c. Dependent's Date of Birth:		_____	
You must attach a receipt or proof of payment stating that the expenses above have been incurred and the amount of the expenses (clearly marked cash register receipt identifying purchase item). An explanation of benefits from your group insurance plan administrator will satisfy this requirement. Canceled checks are not acceptable.			
I certify that the expenses listed above qualify for reimbursement and have been incurred and paid by me or by eligible members of my family. These expenses have not been reimbursed by my health care plan or any other health care plan, such as my spouse's. Bills, statements or other evidence of these expenses are attached.			
Participant's Signature: _____		Date: _____	