HRA Request for Reimbursement of Recurring Expenses
RETIREES ONLY

Complete this form and send with supporting documentation to: **Zenith American Solutions, P.O. Box 1015, Minneapolis, MN 55440-1015.**

- Supporting documentation may consist of: Bills, Premium Notices, Explanation of Benefits, Receipts.
- A separate form must be completed for each eligible dependent.
- Each form of documentation must contain the date(s) of service, provider name, provider address, description of treatment, service or supply, as well as the name of the claimant.
- **PLEASE NOTE**: Do not submit claims for charges eligible for payment under your Insurance or Medicare. This includes all amounts available for reimbursement under Health FSAs unless you have exhausted the account balance. Do not submit claims after twelve (12) months from when you received the medical service or March 31, following the close of the Plan Year in which the Medical Care Expense was incurred. Do not submit claims for services prior to your benefit eligibility date.

PARTICIPANT INFORMATION – MUST BE COMPLETED (Please Print)

Plan Name: **MINNESOTA AND NORTH DAKOTA BRICKLAYERS AND ALLIED CRAFTWORKERS HRA**

Participant's Full Name (Last, First, Middle Initial)

____

Participant's Social Security Number: ________________________

Gender: ☐ Male ☐ Female **Marital Status:** ☐ Married ☐ Single

Date of Birth: ___________________________

Address: ____

____

Is this address a change? _____ Yes ______No

Home Phones: _____________________________

Work Phones: _____________________________

Claim is for: ☐ **Self** ☐ **Spouse** ☐**Dependent Child** ☐**Other Dependent** ☐**Non-Spouse or Non-Dependent Beneficiary**

Claimant's Full Name (Last, First, Middle Initial)

____

Claimant's Social Security Number:

____

REQUEST FOR REIMBURSEMENT OF RECURRING EXPENSES – RETIREES ONLY

Use this section to request automated reimbursement of recurring expenses. Note, payment must be made to the account holder. Payment will not be made directly to an insurance company or other third party. You are responsible for ensuring that the automated reimbursements are for qualifying medical expenses are stopped if you are no longer incurring the expense(s). You must provide documentation of the recurring expense with this request, and you must retain sufficient documentation for all recurring expenses. Zenith American Solutions reserves the right to periodically request documentation for all automated payments.

Begin recurring reimbursement of $___________________________________

Beginning date: Insert date you wish payments to begin (mm/dd/yyyy) ________/________/____________
(Month) (Day) (Year)

Frequency – Check one: ______ Annually ______ Quarterly ______ Monthly ______ Weekly

_____ **Change recurring amount of $**_____________ **to $**_____________ Effective Date of Change (mm/dd/yyyy) _______/_______/___________
(Month) (Day) (Year)

_____ **End recurring payment of $**__________ Ending date, insert date automated payment should cease (mm/dd/yyyy) ______/_____/_________
(Month) (Day) (Year)

#Note, Payments will continue until your account is depleted, unless an ending date is provided.

Read Carefully:

The undersigned certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred by the participant, the participant's spouse, the participant's eligible dependents, or a designated beneficiary (after the participants death only) while the undersigned was eligible to receive benefits under the HRA Plan. The undersigned certifies as follows:

1. The undersigned is retired.
2. The medical expenses have not been reimbursed and are not reimbursable under any other health plan, dental plan, or Medicare.
3. The undersigned acknowledges that all amounts available for reimbursement under Health FSAs have been exhausted.
4. Nonprescription medications for which reimbursement is requested were purchased to alleviate or treat personal injuries or sickness.
5. The undersigned is responsible for requesting cessation of automated reimbursement or recurring expenses when the expense is no longer incurred, and will retain sufficient documentation for all recurring expenses.
6. Zenith American Solutions reserves the right to periodically request documentation for all automated payment requests.
7. The undersigned understands that she/he alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim.
8. The undersigned understands that she/he will be liable for payment of all related taxes including Federal, State, or local income tax on amounts paid from the plan for non-qualifying expenses.

Member's Signature: ____ **Dated:** ____________________________

See Other Side For: Reimbursement of Non-Recurring Expenses-All Members