PLUMBERS & PIPE FITTERS LOCAL #354 BENEFIT FUNDS

c/o FRANK M. VACCARO & ASSOCIATES, INC.
6500 Brooktree Road, Suite 205
Wexford, PA 15090

Phone: (412) 481-1641 or (844) 746-9676
Fax: (724) 799-2284
Email: 354benefits@fmvaccaro.com

Healthcare Reimbursement Account (HRA) Claim Form

Name _____ Social Security Number _____

Address(Street) _____ E-mail Address _____

Address (City, State, Zip) _____ Phone Number _____

Healthcare Expense Claims

Date Expense Incurred (mm/dd/yyyy)	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount

Attach appropriate EOB(s), paid bill(s) and receipt(s) and submit with this claim form	Total Healthcare Expense Claim	$

***Return form along with EOB(s), paid bill(s) and receipt(s) to:**

PLUMBERS & PIPE FITTERS LOCAL 354
c/o Frank M. Vaccaro & Associates, Inc.
6500 Brooktree Road, Suite 205
Wexford, PA 15090
Email: 354benefits@fmvaccaro.com

Read Carefully: The undersigned participant in the Fund certified that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the HRA Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other heath plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim that is provided by the undersigned. The undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Fund if the payment has been reimbursed by another plan.

_____ _____

Participant's Signature **Date**