IRON WORKERS'
Tri-State Welfare Fund

20 N Martingale Road Suite 290
Schaumburg, Illinois 60173
Toll-Free 844-395-4467
Fax 855-978-2331
www.tristatewelfarefund.com
tristateiron@groupadministrators.com

HEALTHY FOUNDATIONS ACCOUNT (HRA) REIMBURSEMENT REQUEST

NAME ______________________________

SOCIAL SECURITY #__________________ PHONE #__________________

ADDRESS ______________________________

REQUEST FOR SELF-PAYMENT

	SELF-PAY AMOUNT	ELIGIBILITY QTR/MONTH(S)
REGULAR SELF-PAYMENT	$ ________	________
COBRA PAYMENT	$ ________	________

For self-payments, complete sections above. If entire self-payment is being requested, you may fax or email. If a check is also included, submit this form and your check to the address indicated on your self-pay letter. For monthly installment payments, this form is required to be submitted for each payment.

REQUEST FOR REIMBURSEMENT OF OOP EXPENSES

EXPENSES (Describe type of expense)	AMOUNT
________	$ ________
________	$ ________
________	$ ________
TOTAL	$ ________

For reimbursement of expenses, complete the information below for payment by direct deposit. You must include an itemized bill, proof of payment, and Explanation of Benefits.

Name of Financial Institution: ________________ ☐ Checking ☐ Savings

Routing Number: ☐☐☐☐☐☐☐☐☐

Account Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Signature:______________________ Date:______________