Coalition of Detroit Public Safety Unions Trust

Health Reimbursement Arrangement (HRA) Claim Form

Instructions

1. Complete Section I - Employee Information
2. Do not staple any documentation to claim form, please tape to separate sheet or include loosely in envelope. Do not send originals (all claims are stored electronically and paper copies will be shredded).
3. Complete Section II - Claims. Attach proper documentation showing the date(s) of service, type(s) of service and cost (No cancelled checks, balance forwards or bank card receipts). Itemize all expenses to prevent delays in reimbursement. If your expense is partially covered by your insurance, you must submit a copy of your Explanation of Benefits (EOB).
4. Complete Section III - Signing the claim form. Claims can be submitted using one of the following methods - fax, email, mail or online. Online claims status is available at www.ushealthandlife.com.

Visit our website abs-tpa.com to view a list of eligible expenses and exclusions.

Section I. Employee Information

First Name _____ MI_____ Last _____

Address_____

City_____ State_____ Zip_____

Day Phone_____ Email Address _____

Employee SSN_____ Union_____

Section II - List Claimed Expenses

Service Dates	Type of Expense	Name of Provider/Store	For Whom	Net Cost
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
			Total Request	$_____

Section III - Signature

To the best of my knowledge and belief, my statements on this claim form are complete and true. I understand that I am solely responsible for the validity of claims submitted to this Plan. I am claiming reimbursement only for eligible expenses incurred by me, my spouse and/or my dependents. Note: The IRS does not recognize Domestic Partners for purposes of receiving tax-favored health benefits. I certify that these expenses have not been reimbursed under this plan or by any other source and that they will not be reimbursed by any other source or insurance. I authorize my HRA to be reduced by the amount(s) shown above.

Participant's Signature_____ Date_____

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