Twin Cities Bakery Drivers Health and Welfare Fund
Pharmaceutical HRA Claim Form

Employer _____ My Phone # _____

Name _____ SSN _____

Address _____

City _____ State _____ Zip Code _____

Please reference your Summary Plan Description for details on your Pharmaceutical benefit.

Please submit documentation that gives the following information:
- Name of Pharmacy
- Name of Person Receiving Prescription
- Date Prescription was filled
- Total Expenses Incurred
- Evidence that payment has been made by the claimant

FOR REIMBURSEMENT OF PHARMACEUTICAL EXPENSES OUT OF YOUR HRA YOU MUST SUBMIT A COPY OF YOUR PRESCRIPTION RECEIPT (not cash register receipt).

-Fill in the lines below, sign your name and attach all required.
-Keep a copy for your records and mail the original with documentation to:

Formula Benefits
Attn: HRA Dept.
2919 Eagandale Blvd., Suite 120
Eagan MN 55121
OR Fax to: 651-686-0513

If you have any questions please call: 651-686-7705 ext. 113; or toll free 1-800-689-7713

IMPORTANT: You have 365 days from the date of service to submit a qualified expense for reimbursement.

Name of Pharmacy	Person Receiving Service	Date Prescription was filled	Total Expenses	Amount Paid By You

TOTALS _____ _____

I hereby certify that the information above is true and correct, and that neither I, my spouse, nor any of my eligible dependents have or will receive reimbursement for any of the expenses listed above from any other source, and furthermore, that I have not, and will not, claim any of these expenses as a deduction on, or in calculating a credit from my/my spouse's income taxes.

Date _____

_____

Participant Signature (*spouse or dependent signatures will not be accepted)*