Twin Cities Bakery Drivers Health and Welfare Fund
HRA Claim Form

Employer | My Phone #

Name | SSN

Address

City | State | Zip Code

Please reference your Summary Plan Description for a listing of qualified expenses and reimbursement percentage.

Please submit documentation that gives the following information:
- Name of Provider or Clinic
- Name of Person Receiving Service
- Type of Eligible Expense
- Date Service was Rendered (not paid)
- Total Expenses Incurred
- Evidence that payment has been made by the claimant

FOR MEDICAL AND DENTAL REIMBURSEMENT AN EXPLANATION OF BENEFITS (EOB) FROM YOUR HEALTH OR DENTAL INSURANCE WILL SATISFY THE ABOVE REQUIREMENTS. *DO NOT SUBMIT CREDIT CARD RECEIPTS OR MONTHLY STATEMENTS.*

-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
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 Provider (Doctor, Dentist, Etc.)	Person Receiving Service	Type of Expense	Date Expense was Incurred	Total Expenses	Amount Paid By You

TOTALS

I hereby certify that the information above is true and correct, and that neither reimbursement I, my spouse, nor any of my eligible dependents have or will receive for any of the expenses listed above from any other source, and furthermo re, 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.above

Date

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

Print Form