NCF
NORTHEAST CARPENTERS FUNDS

Raritan Plaza II, P.O. Box 7818, Edison, NJ 08818-7818
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www.nrccf.org

HRA Reimbursement Form

Member's Name _____ ID # _____

Address, City, State, ZIP _____

Telephone Number _____ Email _____

Check type of reimbursement applied for:

_____ **Medical Expense** _____ **Dental Expense** _____ **Vision/Optical**

_____ **Post-Tax Medical Insurance Premium (Medical, Dental or Vision)**

If you have other insurance, check the type below:

_____ **Dental** _____ **Vision** _____**Medical (other than NCF)**

If you have other insurance, please attach a copy of your ID card for your HRA file.

Reimbursements: Per the IRS, the HRA fund is the payer of last resort. All other insurances must be exhausted first. **You are limited to one form submission/member/month.** Use one form for the entire family and attach unlimited, **original** receipts. You must submit **PAID** detailed bills and corresponding Explanation of Benefits (EOB) if applicable from Insurance showing dates of service, patient name, and diagnosis **along with a receipt showing proof of payment**. **NO PHOTOCOPIES OR FAXES** will be accepted, original bills, Explanation of Benefits and original paid receipts only. **Claim submission deadline is the 15th of every month.** Approved claims will be paid between the 20th and the 25th of each month. Claims must total a minimum of $100.00 (except for January and July when the minimum total can be less than $100.00). You need a minimum HRA balance of $2,000.00 to activate your HRA fund. ***Once activated, HRA money in excess of $1,000.00 can be used for any Eligible Medical Expense. HRA money below $1,000.00 can only be used for post-tax premium payment reimbursements (Medical, Dental, or Vision premiums).**** Per IRS guidelines, only Post-Tax insurance premiums are eligible for reimbursement from the HRA. Post-taxed means that the insurance premiums are deducted after taxes are taken from your gross wages. Submit pay stubs showing deductions for medical premiums or a letter from the employer verifying the post-tax health insurance premiums including the cost to the employee.

Timely filing is required: You have one year from the date of service (DOS) to submit a bill.

FRAUD WARNING: *Any person who knowingly files a claim containing any false information is subject to criminal and civil penalties. I hereby certify that the paid expenses submitted are for my-self, my legal spouse, or my legal dependent and we are not covered under any other insurance policy that has not been declared.*

Member's Signature _____ **Date:** _____

**Revised 4/14/2016* *Download form at nrccf.org*