



Health Reimbursement Arrangement Reimbursement Claim Form

Complete a separate form for each covered family member

Pipeline Industry Benefit Fund


Employee Name _____

I.D.# _____

Phone _____

E-mail _____

Healthcare Expense Claims

Date Expense Incurred	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount
 Attach appropriate receipt(s) and submit with this claim form.		Total Healthcare Expense Claim		

Read carefully: The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the Pipeline Industry Benefit Fund Health Reimbursement Arrangement with respect to such expenses and that the medical expenses have not been and will not be reimbursed under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned maybe liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense.

I further certify that such items will not be deducted or taken as tax credits on my personal federal and/or state income tax return for any year. Your Health Reimbursement Arrangement (HRA) Plan may be limited to the types of healthcare expenses that may be reimbursed to you.

Employee's Signature

Date

Checks will be mailed to address on file unless otherwise specified.

Mail Claim Form and Receipts to:
Pipeline Industry Benefit Fund
P.O. Box 470950, Tulsa, OK 74147-0950