lighthouse1 SPENDING ACCOUNT SELF SERVICE

ITW

HRA Reimbursement Request

INSTRUCTIONS

1. Complete this form to submit claims for eligible health care expenses from your Healthcare Reimbursement Account (HRA).
2. Include only expenses eligible for reimbursement as defined by federal regulations and not previously submitted with a claim.
3. Submit a copy* of your Explanation of Benefits and documentation from the provider that includes the following information:
   - Patient or dependent name
   - Date of service
   - Description of service
   - Expenses incurred
   - Proof of Payment

   * Only send copies of documentation. Keep your original documentation for future reference
4. Sign and date this form then send to the address noted below by mail or fax with all documentation needed for processing.

RETIREE INFORMATION (please print clearly)

Retiree/Surviving Spouse Name (Last, First, MI)	Date of Birth ___/___/_____	Employee ID

Home Address (Street, City, State, Zip Code)

HEALTH CARE REIMBURSEMENT REQUEST

Date of Service	Name of Service Provider	Expense Description (Rx, office visit, etc.)	Person for Whom Expense is Incurred	Expense
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
			TOTAL	$

RETIREE AUTHORIZATION

I verify that the enclosed expenses are eligible for reimbursement from the applicable account under my Healthcare Reimbursement Account and that they qualify as deductions according to IRS regulations. I request reimbursement up to the limit allowed based on my election. I further verify that these expenses have not been reimbursed and are not reimbursable under any other benefit plan.

Retiree/Surviving Spouse Signature _____ Date: ___/___/_____

Please return completed form via mail or fax to:

ITW Benefits Service Center
P.O. Box 3970
Manchester, NH 03105

Toll Free Number: 1-866-416-4931
Toll Free Fax: 1-866-490-0319