# LOCAL 773 BENEFITS OFFICE


*Northeastern New York District Council Pipefitters Welfare Fund*
*Plumbers & Pipefitters Local 773 Annuity Fund*
*Plumbers Local 773 Pension Fund*
P. O. Box 312
Glens Falls, NY 12801

CHRISTOPHER BAXTER
Fund Administrator

Phone: (518) 792-0586
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**CERTIFICATION AND HOLD HARMLESS AGREEMENT**
For
**HEALTH REIMBURSEMENT ACCOUNT CLAIMS**

I hereby apply for Health Care Assistance Benefits from the Northeastern New York District Council Pipefitters Welfare Fund.

I certify that I have incurred health care expenses for : *(please list)*

□ myself
□ my spouse ___________________________
□ my dependent children ___________________, _________________________, __________________________

__________________________, ___________________________, ______________________, ______________________

and that such health care expenses are not covered nor have they already been paid by the Welfare Fund' s Insurance Benefit or by any other insurance program (including insurance coverage maintained by my spouse).

I certify that the information on this form, and any attachments is accurate and complete. I am requesting reimbursement for eligible medical expenses incurred by myself or an eligible dependent. I, or my dependents, have already received these product(s) or service (s) and have not and will not seek reimbursement of these expenses from any other plan or party. I have not and will not claim these expenses as a tax deduction under IRS code 213.

I understand that submitting a fraudulent claim or falsifying information may result in the forfeiture of any funds in my HRA account.

**Copies of the paid bills, with proof of payment and service date are attached. Original receipts for any requested Over-The-Counter purchases are attached.**

I hereby agree to reimburse the Welfare Fund for any sums it pays in reliance on these certifications if they prove to be inaccurate or false, and to indemnify the Trustees of the Welfare Fund, and hold them harmless, against any costs, expenses or damages they may incur or suffer as a result of any such inaccuracy or falsity.

I hereby grant the Local 773 Benefit Office staff permission to access any billing information from my healthcare provider (s) and/or the billing information for my dependent(s), should verification of service dates, or expense and payment information be required.

| Member Name (Print) | Member Signature |
|---|---|
| Date: | You may enter either your social security number or your UA Card # on the next line. |
| Member's Social Security # | Members UA Card # |
| Member Address: Is this a change? □YES □NO<br><br>______________________________<br>Street or PO Box | <br><br>______________________________<br>City, State, Zip |
| Witness Name (Print) [NOT SPOUSE or DEPENDENT] | Witness Signature |