PAYMENT AUTHORIZATION

HRA – COBRA/Unemployment/ Workers' Comp./Disability/ Retiree Continuation of Coverage

PLUMBERS LOCAL UNION No.1 WELFARE FUND

50-02 5th Street, LIC, NY 11101
www.ualocal1funds.org
Tel. 718-223-4313 / 718-835-2700 Fax. 718-641-8155

(A) Member Information

[redacted] - [redacted] - ____

(1) Social Security Number | (2) Last | (3) First | (4) Init.

(5) Street | (6) City | (7) State | (8) Zip

(9) **Telephone Number** (10) **Date of Birth** (11) **Retired** (12) **Marital Status**

(_____) _____-_____ _____ Month Day Year ☐ ☐ ☐ngle ☐arried ☐ivorced ☐Widowed

(B) How to pay COBRA, Unemployment, Workers' Compensation, Disability or Retiree Continuation of Coverage with your HRA reimbursement

1. Complete Line 1 of Section C of the enclosed Health Reimbursement Arrangement (HRA) Claim Form by (a) listing the Expense Type as Medical **"(MD)"**, (b) Date of Service as **"month(s)/Year"** that you are paying COBRA, Unemployment, Workers' Compensation, Disability or Retiree Continuation of Coverage, (c) **Provider Name"** as Welfare Fund, (d) Charges Incurred as **"Self-Pay"** payment amount(s), (e) Health Plan Payment as **"$0.00"**, and (f) Net Out-of-Pocket Expenses as **"Self Pay**" payment amount(s).
2. If you are also seeking other HRA reimbursements a separate HRA claim form is required.
3. File a separate claim form for each month that you are seeking to pay with your HRA reimbursement. For COBRA and Retiree Coverage you can also pay multiple months by listing the number of months that you are seeking to pay. You can do this by listing the beginning month/year under date of service in line 1 and ending month/year under date of service in line 2.
4. Submit a separate payment on or before the due date in the event that your HRA account balances are insufficient and/or depleted.

(C) COBRA, Unemployment, Workers' Compensation, Disability or Retiree Continuation of Coverage Self-Payment

Self-Payment is for the month(s) of From ☐☐ - 2 0 ☐☐ (Month / Year) To ☐☐ - 2 0 ☐☐ (Month / Year)

___ COBRA

___ Unemployment Continuation of Coverage

___ Workers' Compensation Continuation of Coverage

___ Disability Continuation of Coverage

___ Retiree Continuation of Coverage

___ Permanent Disability Retiree Continuation of Coverage

(D) Members Signature and Authorization - Complete to assign HRA Reimbursement payment to Welfare Fund.

By signing this form you certify that: (1) you authorize listed payment(s) directly to the Plumbers Local Union No. 1 Welfare Fund. (2) You assume the responsibility of submitting a separate COBRA, Unemployment, Workers' Compensation, Disability or Retiree Continuation of Coverage payment on or before the due date in the event that your Health Reimbursement Arrangement account balances are insufficient and/or depleted.

Member's Signature: _____ **Date:** _____
SIGNED (MEMBER)