

**TEAMSTERSCARE HEALTH BONUS ACCOUNT  
(HBA) CLAIM FORM**

**MAIL CLAIM FORM TO:  
TeamstersCare Member Services  
16 Sever Street, Charlestown, MA 02129-1309**

Member Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_

**EXPENSES FOR WHICH YOU REQUEST REIMBURSEMENT**

Name of Person Receiving Service or Supplies	Relationship to Member	Provider of Service or Supplies	Date of Service	Type of Service or Supplies	Amount to Be Reimbursed

**CERTIFICATION**

To the best of my knowledge, the above information is accurate. I am requesting payment only for eligible expenses incurred during the period for which I am eligible, and only for those expenses not eligible for payment under any other benefit plan. I will not deduct these expenses on my individual federal tax return.

\_\_\_\_\_  
Member's Signature

\_\_\_\_\_  
Date

# Instructions

1. Complete **all** sections on the reverse side of this form. **You must sign and date the form.**
2. Be sure that you first submit all expenses to any other benefit plan for which the patient is eligible. You may then apply for reimbursement of the expenses not covered in part or in full. You may not request reimbursement until you have received the service, regardless of when you pay for it.
3. Attach legible **copies** of your bills or receipts for each of the expenses you list (**cancelled checks or charge card receipts are not valid**). You should accumulate your bills and then submit them together as a single claim.  
**TeamstersCare will issue Health Bonus checks to members only. Checks will be issued four times per year (October 31, January 31, May 31, and July 31).**
4. The attached copies of itemized bills must include:
  - Name of person receiving the service/supplies
  - Name of person/organization providing the service/supplies
  - Date that service/supplies were provided
  - Description of service/supplies (if prescription drugs, bill should include prescription number, name of medication, date of purchase, and name of prescribing physician)
  - Total charge for the service/supplies (amount for which you are requesting reimbursement)**Keep your original** bills and proofs of payment for your records.
5. If expenses were first submitted to another plan, attach the notice (Explanation of Benefits/EOB form) from the plan that explains the amount reimbursed.
6. Send this completed Health Bonus Account Claim Form and copies of your paid bills to TeamstersCare Member Services, 16 Sever Street, Charlestown, MA 02129-1309. You may want to keep a copy of the form for your records.
7. According to IRS regulation, any unused year-end balance in your Health Bonus Account may not be carried over to the next Plan Year. Claims for the previous year must be submitted by March 31.