Town of Wellesley Health Reimbursement Arrangement Claim Form
THIS FORM MUST BE FILED BY JULY 31, 2024

Cafeteria Plan Advisors
An Alera Group Company
120 Longwater Drive, Suite 102
Norwell, MA 02061

(781) 848-9848 (Phone)
(781) 848-8477 (Fax)
info@cpa125.com (Email)

EMPLOYEE: _____ **SS#:** _____ -_____ - _____

ADDRESS: _____**CITY:**_____

STATE: _____ **ZIP:** _____**PHONE: ( )**_____**E-MAIL:** _____

Reimbursement for subscriber and family members enrolled in the Benchmark Health Insurance plans.

MEDICAL CARE CO-PAYMENTS UP TO $200 INDIVIDUAL OR $600 FAMILY

EXPENSES MUST BE OCCURRED BETWEEN JULY 1, 2023 TO JUNE 30, 2024

Type Of Medical Care <u>Co-Payment</u> Expense: *(*deductible expenses not eligible*)*	**Reimbursable <u>Co-Payment</u> Amount**	**# of Co-Payments**	**Dates of Service**	Total Reimbursement (Number times reimbursable amount)
Example:		*2*	*1/1+5/31*	*$60*
Office visit—Specialist Care $60+	$30 per visit			
Urgent Care *(No ER Co-payments)*	$20 per visit			
Same-day Surgery	$100 per incident			
Imaging Copay (MRI, CAT SCANS, PET SCANS)	$50 per incident			
Mail Order Prescriptions $75+	$25 per prescription			

TOTAL CLAIM AMOUNT: $_____

This is to certify that I have incurred the expenses listed above that qualify for reimbursement under the Town of Wellesley Health Reimbursement Arrangement. I have not been reimbursed from any other source including insurance programs or other programs offered by my employer. None of these expenses have previously been submitted. I understand and agree that since these expenses are to be reimbursed they may not be claimed as deductions for income tax purposes. I hereby request reimbursement for these claims. ***All claims submitted require receipts showing both the date and description of the expense was applied to a 'co-payment'.***

PARTICIPANT'S SIGNATURE: _____ **DATE**: _____

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