# Town of Wellesley Health Reimbursement Arrangement non-Medicare Retiree Claim Form
## THIS FORM MUST BE FILED BY JULY 31, 2026

Cafeteria Plan Advisors
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Norwell, MA 02061

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**info@cpa125.com (Email)**

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

**ADDRESS:** _____**CITY:**_____

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

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

**EXPENSES MUST BE INCURRED BETWEEN JULY 1, 2025 TO JUNE 30, 2026**

**HRA PLAN #1 - MEDICAL CARE COPAYMENTS (UP TO $200 INDIVIDUAL OR $300 FAMILY)**

| Type Of Medical Care Expense | Reimbursable Co-Pay Amount | # | Dates of Service | Total Reimbursement |
|---|---|---|---|---|
| *Example:* | | *2* | *1/1+5/31* | *$60* |
| Specialist Office Visit ($60+) | $30 per visit | | | |
| Urgent Care (NO ER) | $20 per visit | | | |
| In-patient admission | $200/$400 ($400 for copays in excess of $500) per admission | | | |
| Same-day Surgery | $100 per incident | | | |
| Imaging ($100) (MRI, PET SCANS, CAT SCANS) | $50 per incident | | | |
| Mail Order Prescriptions ($75+) | $25 per prescription | | | |

**TOTAL AMOUNT: $**_____

**HRA PLAN #2 DEDUCTIBLE EXPENSES ONLY (UP TO $150 INDIVIDUAL OR $450 FAMILY)**

Check one: Individual: ☐ Family : ☐

| Date of Service: | Provider | Type of Service | Amount |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**TOTAL 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 for the portion claimed above from any other source including insurance programs or other programs offered by my employer, such as FSA. 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 require a copy of your Explanation of Benefits/Claim Summary from the insurance company showing both the date and description of the copayment along with a completed claim form.***

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