

**City of Everett  
Health Reimbursement Arrangement (HRA)  
Claim Voucher**

Cafeteria Plan Advisors, Inc.  
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EMPLOYEE: \_\_\_\_\_ SS#: xxx-xx-\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ PHONE: (     ) \_\_\_\_\_ E-MAIL: \_\_\_\_\_

**Plan Year: JULY 1, 2018 - JUNE 30, 2019**

Reminder: All expenses must be incurred within the plan year. Once you have incurred an eligible expense simply submit a copy of your **Explanation of Benefits/Claim Summary** from your insurance company along with a completed claim form

<b>Copayments below are reimbursed at 50% per occurrence</b>	<b>Date of Service</b>	<b>Copay Amount</b>	<b>Total Reimbursement ( @ 50%)</b>
<i>Example:</i>	<i>7/1/18 – 7/11/19</i>	<i>100.00</i>	<i>\$50.00</i>
Outpatient Surgery Copay (up to \$75 per occurrence)			
In-patient Hospital Admission Copay (up to \$350 per occurrence)			
High Tech Imaging Copay MRI, CT, PET Scans (up to \$50 per occurrence)			

**TOTAL CLAIM AMOUNT: \$\_\_\_\_\_**

This is to certify that I have incurred the expenses listed above that qualify for reimbursement under the City of Everett 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 medical claims must be submitted within 30 days after the plan year ends and require copies of the Explanation of Benefits/Claim Summary from your insurance company.**

PARTICIPANT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_