

**Town of Wellesley Health Reimbursement Arrangement Claim Form**  
**THIS FORM MUST BE FILED BY JULY 31, 2023**

Cafeteria Plan Advisors  
 An Alera Group Company  
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 Norwell, MA 02061

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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, 2022 TO JUNE 30, 2023**

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