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, 2020 - JUNE 30, 2021

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.

Copayments below are reimbursed at 50% per occurrence	**Date of Service**	**Copay Amount**	**Total Reimbursement** *(@ 50%)*
Example:	***7/1/20 – 7/11/21***	***100.00***	***$50.00***
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**: _________________

Rev. 7.1.20