HRA
CLAIM FORM

HRA Plan Year: July 1, 2016 - June 30, 2017

Employer: **Town of Norton – HRA**

Employee:_____SSN: xxx-xx-_____

Street:_____City: _____

State:_____Zip:_____ Phone: _____

Email: _____

Reimbursements for Eligible Participants in the Town plans:	**Start/End Dates of Service**	**Deductible or Co-pay Total**	**50% of Total (Amount to be Reimbursed)**
Plan Year Deductible *$250 Individual (plan reimburses up to $125)* *$750 Family (plan reimburses up to $375)*	-		
In-Patient Hospital Admission Co-pay *$300 Tier 1 (plan reimburses up to $150)* *$700 Outside Tier 1 (plan reimburses up to $350)*	-		
Outpatient Surgical Co-pay *$150 (plan reimburses up to $75)*	-		
Total			**$**

- All claims ***require*** a copy of the Explanation of Benefits/Claim Detail from the provider or Blue Cross Blue Shield showing both the date and description of the services and the deductible amount or co-pay that you paid
- Claims must be submitted no later than 60 days after the plan year (July 1 - June 30) ends

This is to certify that I have incurred the expenses listed above and that they qualify for reimbursement under the Town's Plan. I hereby request reimbursement for these expenses.

Participant's Signature:_____Date: _____

Mail to:		**Fax to:**		**Scan and Email PDF file to:**
Cafeteria Plan Advisors, Inc 420 Washington St. Suite 100 Braintree, MA 02184	**OR**	781-848-8477	**OR**	Info@cpa125.com