Generic
Health Reimbursement Arrangement (HRA)
Claim Voucher

Cafeteria Plan Advisors
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EMPLOYER: _____

PARTICIPANT NAME: _____ **SS#: xxx -xx -** _____

MAILING ADDRESS: _____**CITY:**_____

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

All expenses must be incurred within the plan year

Eligible Expense/Service ***(see your plan details):***	**Date of Service**	**Copay Amount**	**Total Reimbursement**
Example: (if eligible) Office Visit Copay	***7/1/12 – 7/31/12***	***$25.00***	***$25.00***

TOTAL CLAIM AMOUNT: $_____

This is to certify that I have incurred the expenses listed above that qualify for reimbursement under the 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 claim summary/explanation of benefits from your insurance company.

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