CITY OF ALVA

HRA

Health Reimbursement Account

Blue Cross Blue Shield $2,500 Deductible

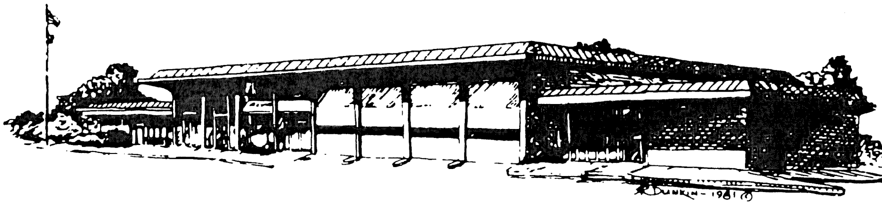
First $500 of Deductible is Employee's Responsibility

Next $501 to $2,000 of Deductible the Plan Will Reimburse Up to $1,500 to Any Individual Or Up to $1,500 For a Family

$500	$501 to $2,000	$2,001 to $2,500
Employee	Employee or Family $1,500 Max	Employee

EOB (Estimate of Benefits) Must Be Handed to the City of Alva For Reimbursement

$50.00 minimum required for all reimbursements.



CITY OF ALVA
415 4th Street
Alva, Oklahoma 73717
(580) 327-1340
Fax: (580) 327-4965

HRA REIMBURSEMENT REQUEST FORM

Name: ______________________________

Address: ______________________________

Social Security Number: ______________________________

Work Phone: ____________________ Home Phone: ____________________

Plan Participant

In order to request reimbursement through the City of Alva HRA benefit you must complete this form, attach a copy of your Explanation of Benefits (EOB) showing amount of deductible met provided by your health plan and sign below.

Date of Expense	Name/Relationship (You must indicate Self, Spouse or Child)	Type of Expense	Total Expense
		Total	

I certify that the expenses listed above have been incurred by me and/or my eligible dependents and qualify for reimbursement. I have not been reimbursed for these expenses nor are the expenses reimbursable under any other health and/or dependent care assistance plan. I am not applying these expenses toward any federal or state income tax deduction or credit. I will assume all responsibility for any taxes or penalties arising out of any disallowed deductions.

______________________________ ____________________

Signature Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.