City of Newburyport
Section 105 Healthcare Reimbursement Plan
Request Form- Plan Year 2018-2019

Employee Name:	
Social Security Number:	Daytime Phone Number:
Email:	**New Email: Yes or No**
This form must be accompanied by a prescription record reflecting the amount you have paid for RX or the claim cannot be processed. You may be asked to provide other types of acceptable proof of claim documents. See Summary Plan Description for Complete Explanation of Benefit.	

Covered Expenses

Employees and Retirees

For employees or retirees enrolled in BCBS Network Blue New England $250 Deductible, Network Blue Select $250 Deductible, Blue Care Elect $250 Deductible or the Medex 2 Plan

Individual or family Coverage: After each enrolled participant has paid the first $400.00 of prescription costs (RX) this plan will reimburse additional RX expenses thereafter so long as there are available funds. See your Summary Plan Description for full details based upon which health plan you are enrolled in.

Under 'cost' enter the amount that you expect to be reimbursed based upon what the EOB says is your responsibility.		
Date of Service	Expense Type	Cost
		$
		$
		$
	TOTAL:	$

I certify that the following reimbursement submissions are for expenses incurred for my spouse, my eligible dependents or myself. I will not claim credit for these expenses on my individual income tax returns and I will not receive payment from any other source for any of these expenses.

_____ _____

Signature Date

Mail or Fax to: ADVANCED BENEFIT STRATEGIES
Attn: Section 105 Administration
30 Mill Street Unionville, CT 06085
Fax (860) 673-2207 Tel (877) 732-8125

06/08 funded