NORTHVIEW PUBLIC SCHOOLS
4365 HUNSBERGER AVENUE NE
GRAND RAPIDS, MI 49525
(616) 363-6861

Flexible Benefits Plan
REQUEST FOR REIMBURSEMENT

Employee Name: (Please type or print) ____Social Security #______________________

Employee address: ____
Street City State Zip

Dependent Care

LIST EACH RECEIPT SEPARATELY (Use additional forms if necessary.)

A Name of Dependent	Age	B Provider Name	Provider ID#	C Dates Services Provided	D Requested Amount of Reimbursement	Office Use Only

Please attach a receipt or itemized bill containing (A), (B), (C) and (D). Cancelled checks, or bills showing a payment or previous balance only, are not acceptable.

Unreimbursed Medical

LIST EACH RECEIPT SEPARATELY (Use additional forms if necessary.)

A Patient Name	B Provider Name	HMO	C Description of Services	D Dates Service Provided	E Requested Amount of Reimbursement	Office Use Only

Please attach a third-party receipt, itemized bill or Explanation of Benefits (EOB) containing (A), (B), (C), (D) and (E). Cancelled checks, credit card receipts, or bills showing a previous balance or balance due only, are not acceptable.

I request reimbursement from my Flexible Spending Account(s) as listed above and certify that these are eligible Medical or Dependent Care Expenses that I or my dependents have incurred. I understand that Medical expenses must qualify as deductible expenses for Federal Income Tax purposes, and cannot be reimbursed by any other source or used as a deduction on my personal income tax return(s). I understand and agree that Dependent Care Expenses must qualify for the dependent care tax credit and that I cannot claim the tax credit for expenses submitted hereunder. I also understand and agree that the taxpayer identification (Social Security) numbers of any dependent care service provider(s) will be supplied to the IRS on my annual tax return.

Date:______________________________ Employee Signature: ____

How to File a Request for Reimbursement

1. Complete the reverse side of this form, including signature and date. Failure to complete all areas can result in a delay in processing and claim reimbursement.

2. Attach itemized bills, receipts or Explanation of Benefits (EOBs) that show:
   - name of person receiving service
   - nature of service or supplies furnished and charges for each item
   - date(s) of service
   - name of provider(s), address and tax identification number (Fed ID# or Social Security#)

3. If you carry group medical insurance, first submit expenses to the insurance carrier. Attach the Explanation of Benefits (EOB) to document any reimbursement or credit to your deductible.

4. If your service was provided through an HMO, check the appropriate space in Box B.

Qualifying Expenses

To qualify for reimbursement, expenses must be incurred during the Plan Year for which you are requesting reimbursement (October 1 through September 30) and reimbursement requests must be submitted no later than December 31 (90 days) following the end of each Plan Year.

1. **Medical Reimbursement Account** – can be used for medical expenses for you or your family that are not covered by any other health plan. Items covered include, but are not limited to:
   - deductibles/coinsurance
   - medical, dental & visions services
   - hearing exams or aids

2. **Dependent/Child Care Reimbursement Account** – reimburses for care of your child or other tax dependent while you are at work. For services at a dependent care center, the center must comply with all state and local laws.

   Specifications for this account are:
   - Your child must be age 12 or under.
   - Your child or other dependent over the age of 13 must be incapable of self support and spend 8 hours or more a day in your home.
   - The individual caring for your child age 12 and under or other dependent must not be a tax dependent.
   - Reimbursement cannot exceed $5,000 annually ($2,500 if married filing separate returns) or the earned income of you or your spouse, whichever is less.
   - The taxpayer identification (and/or Social Security) number of any dependent care service provider must be supplied to the IRS on your annual tax return.

SUBMIT COMPLETED *REQUEST FOR REIMBURSEMENT* TO:

Payroll / Administration Office
Northview Public Schools
4365 Hunsberger Avenue NE
Grand Rapids, MI 49525