PORTLAND PUBLIC SCHOOLS
EMPLOYEE BENEFIT PLANS

CLAIM FOR REIMBURSEMENT

Participants Name_____ **Social Security #**_____

HEALTH CARE EXPENSE CLAIM

Date Expense Incurred	Name of Service Provider	Expense Description	Person for Whom Expense was Incurred	Net Claim

DEPENDENT CARE EXPENSE CLAIM

Name of Dependent(s)	Period Covered		Name of Service Provider And Identification Number	Net Claim
	From	To		

The undersigned Participant certifies that all expenses for which reimbursement is claimed by submission of this form were incurred during the Plan Year. With respect to Health Care claims they have not been reimbursed or are not reimbursable under any other insurance coverage. With respect to Dependent Care claims that the amount claimed does not exceed the maximum amount allowed by law. I certify that all services were provided to individuals qualified as dependents under the plan(s). The undersigned understands that he/she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim and that the undersigned may be liable for payment of all related taxes for any claims later deemed to be not qualified under the plan or IRS Code.

_____ _____

Employee's Signature Date

RETURN CLAIM FORM & EXPENSE VERIFICATION TO:
CENTRAL ADMINISTRATION OFFICE
1100 IONIA ROAD
PORTLAND, MI 48875

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