**16868-****{stdMbrPERSLinkID}**



**FLEXCOMP REIMBURSEMENT VOUCHER**

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 16868 (Rev. 12-2010)

**NDPERS • PO Box 1657 • Bismarck • North Dakota 58502-1657**

**(701) 328- 3900 • 1-800-803-7377 • Fax 701-328-3920**

**Read SFN 16868 Instructions Before Completing**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PART A EMPLOYEE INFORMATION** | | | | | | | | | | | | | | | | | | |
| Plan Participant’s Name (Last, First, Middle) {stdMbrFullNameLFM} | | | | | | | | Employee Id **(Required)** {stdMbrPeopleSoftID} | | | | | | NDPERS Member Id {stdMbrPERSLinkID} | | | | |
| Last Four Digits of Social Security Number {stdMbrLastFourDigitsOfSSN} | | | | | | | Date of Birth {stdMbrDateOfBirth} | | | | | | Work Phone Number | | | | | |
| **PART B MEDICAL EXPENSES** Check box if you want expenses incurred in grace period, January 1 to March 15, reimbursed  from previous plan year account balance. | | | | | | | | | | | | | | | | | | |
| **Service Date** | **Provider Name** | | | | | **Amount** | | | **Service Date** | | **Provider Name** | | | | | | | **Amount** |
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| **Total Medical Reimbursement Request: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | | | | |
| **PART C NDPERS USE ONLY** | | | | | | | | | | | | | | | | | | |
| Service From | | Service To | | | Submitted Amount | | | | | Denied Amount | | | | | | Claim ID | | |
| **PART D DEPENDENT CARE EXPENSES** Check box if you want expenses incurred in grace period, January 1 to March 15,  reimbursed from previous plan year account balance. | | | | | | | | | | | | | | | | | | |
| **Provider Name (If provider is a relative, list relationship)** | | | **Tax ID or SSN** | **Provider’s Signature** | | | | | | | | **Expense Dates** | | | | | **Amount** | |
| **From** | | | **Through** | |
|  | | |  | |  | | | | | | |  | | |  | |  | |
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| **Total Dependent Care Reimbursement Request: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | | | | |
| **PART E NDPERS USE ONLY** | | | | | | | | | | | | | | | | | | |
| Service From | | Service To | | | Submitted Amount | | | | | Denied Amount | | | | | | Claim ID | | |
| **PART F CERTIFICATION – READ CAREFULLY** | | | | | | | | | | | | | | | | | | |
| The undersigned participant in the Plan certifies the following:   * All expenses for which reimbursement is claimed by submission of this form were incurred during a period while the undersigned was a participant in the Plan. * The expenses were for services received by the participant or his/her eligible dependent(s) as defined in the Flexcomp Plan. * The expenses have not been reimbursed and are not reimbursable under any other health plan coverage. * Any dependents for which the participant selected dependent care benefits reside in a parent/child relationship and/or are legally dependent on the participant for their support. The child must reside with the employee for more than half of the taxable year. * The undersigned agrees that the reimbursement associated with their dependent care reimbursement request is for dependent care expenses that have been incurred. * The undersigned fully understands that he or she alone is fully responsible for the accuracy of all information relating to this claim and that unless an expense for reimbursement is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, and FICA tax on amounts paid from the Plan which relate to such expense.   Plan Participant’s Signature Date of Signature | | | | | | | | | | | | | | | | | | |