



**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)	Employee Id (Required)	NDPERS Member Id
Last Four Digits of Social Security Number	Date of Birth	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

Total Medical Reimbursement Request: \$ \_\_\_\_\_

**PART C NDPERS USE ONLY**

Service From	Service To	Submitted Amount	Denied Amount	Claim ID
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**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	

Total Dependent Care Reimbursement Request: \$ \_\_\_\_\_

**PART E NDPERS USE ONLY**

Service From	Service To	Submitted Amount	Denied Amount	Claim ID
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**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