FLEXCOMP REIMBURSEMENT VOUCHER

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 16868 (Rev. 09-2009)

NDPERS ▪ PO Box 1657 ▪ Bismarck ▪ North Dakota 58502-1657
(701) 328- 3900 ▪ 1-800-803-7377 ▪ Fax 701-328-3920

Reset

Read Instructions Before Completing This Form

PART A PARTICIPANT INFORMATION

Plan Participant's Name (Last, First, Mi)		Employee ID Number (**Required**)
Department Name	Department Number	Work Telephone 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

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

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 dependent(s) as defined in the 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

ORIGINAL TO NDPERS – PLEASE RETAIN A COPY FOR YOUR RECORDS