NORTHWEST GROUP SERVICES

Flexible Spending Account

Claim for Reimbursement

Instructions

1. Before completing this form, make sure your expenses qualify for reimbursement.
2. You must submit all covered health care expenses to your and/or your spouse's health insurance carrier before submitting a FSA reimbursement.
3. Complete this form as instructed below.
4. Mail this form with receipts to the address below.

Personal Information - Please correct any information which is not accurate.

5420 — Group Number

Midview Local School District — Employer Name

Social Security Number | Your Last Name | First Name | M.I.

Home Address

City | State | Zip Code | Daytime Phone Number (please add)

Health Care Expenses - Please check the appropriate box(es) to identify the expenses you are submitting.

[ ] Expenses covered by a benefit plan: You must first submit the expenses to your insurance company and , if applicable, your spouse's insurance company. Attach a copy of all applicable Explanation of Benefits (EOB) to this form to service reimbursement for any expenses not covered.

[ ] HMO/DMO copayments: Attach a copy of the itemized bill indicating copayments.

[ ] Expenses not covered under any benefit plan: Attach a copy of the itemized bill showing the provider's name, date of service, services provided and the amount charged.

[ ] Orthodontia expenses: Attach your paid receipt or payment coupon.

Total Health Care charges being submitted for reimbursement: $_____

Dependent Care Expenses - Your dependent care provider must sign this form verifying charges incurred OR you must submit a receipt from the provider for services rendered. An expense is incurred when the service is provided, not when you pay for it.

Services must be provided during the plan year and must be incurred prior to reimbursement of your claim. If you prepay your provider, you can submit this form after the first date of service, but not more than 30 days before the last date of service. (For example, if the dates of service are 4/1 through 4/30, you should not sign the form and submit the claim prior to 4/1.)

Provider (print) _____ Dates of Service ____/____/____ to ____/____/____

Total Dependent Care charges being submitted for reimbursement $ _____

I certify that the above listed charges have been incurred.

Signature of Provider _____ Date ____/____/____

IMPORTANT: You are required to provide the name, address and taxpayer identification number or social security number of your dependent care provider when you file your income tax return. If you are unable to provide this information, the deduction for the Dependent Care FSA may be denied by IRS.

Signature

I certify that the expenses listed above have been incurred by me and/or my eligible dependents and qualify for reimbursement. I have not been reimbursed for these expenses nor are the expenses reimbursable under any other health and/or dependent care assistance plan. I am not applying these expenses toward any federal or state income tax deduction or credit.

Your Signature _____

Date _____

Mail this form with receipts to

N.W.G.S. (TPA Services)
1910 Indianwood Circle
Suite 101
Maumee, Ohio 43537

Questions: 1-888-808-3008
Local Number: 419-887-1215
Fax Number: 419-887-1214