

Forms or receipts will not be returned. If you wish to retain a copy for your records, please copy before submitting to Northern

## REIMBURSEMENT REQUEST FORM

<b>CHANGE OF ADDRESS ONLY</b>
New Address _____
City _____
State, Zip _____

**COMPANY NAME:** \_\_\_\_\_ **EMPLOYEE NAME:** \_\_\_\_\_

**EMPLOYEE #:** \_\_\_\_\_ **~OR~ SS #:** \_\_\_\_\_

**TELEPHONE(S) #** \_\_\_\_\_ (Phone calls are made only on denials of \$150 or more, you will not be contacted if you don't provide a #)

Please check which type of expense is being claimed.     **Medical Care**     **Dependent/Day Care**     **PHIP** (If Applicable)

**NOTE: Please do not mix different Claim Types on the same form. A separate claim form is needed for each Claim Type.**

**DIRECTIONS:** Please attach all documentation for items you have listed below. Documentation must provide 1) Date of Service 2) Description of Service 3) Service Provider Name 4) Name of Patient (Unless over the counter receipt) 5) Amount being charged to you. **Cancelled checks or credit/debit card receipts are not acceptable documentation.** This form must be complete with documentation to be reviewed for payment. Please see back of form for further information.

**(IMPORTANT! All claims personally dropped off at our office must be in a sealed envelope.)**

Date of Service	Service Provider	Expense Description	Person receiving service	Self or Dependent	Net Amount
1.				S or D	\$
2.				S or D	\$
3.				S or D	\$
4.				S or D	\$
5.				S or D	\$
6.				S or D	\$
7.				S or D	\$
8.				S or D	\$
9.				S or D	\$
10.				S or D	\$

(NIA Office Use Only) **AUTHORIZED BY:** \_\_\_\_\_ **AMOUNT:** \$ \_\_\_\_\_

**READ CAREFULLY:**

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the Company's Cafeteria Plan and that these expenses have not or are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state or city income tax on amounts paid from the Plan which relate to such expense. They further recognize that any unused amounts in their account after the close of the Plan year will be forfeited and that they have a specified time period in which to submit qualified expenses following the end of the Plan year or upon termination of participation. **The undersigned also accepts responsibility for paying expenses incurred to the provider of such expenses.** The undersigned is also acknowledging that they have fully read and understand the back side of this claim form.

**DEPENDENT CARE NOTE:** THE MAXIMUM AMOUNT OF REIMBURSEMENT UNDER THIS PLAN IS LIMITED TO THE SMALLEST OF THE FOLLOWING: A) \$5,000 IF MARRIED FILING JOINT RETURN OR IF EMPLOYEE IS A SINGLE PARENT, B) \$2,500 IF MARRIED FILING SEPARATE RETURNS, C) THE EMPLOYEE'S EARNED INCOME FOR THE PLAN YEAR OR THE EARNED INCOME OF YOUR SPOUSE, D) IF YOUR SPOUSE IS EITHER A FULL-TIME STUDENT OR IS INCAPABLE OF TAKING CARE OF HIMSELF OR HERSELF, THEN HE OR SHE IS DEEMED TO HAVE MONTHLY EARNINGS OF \$200 IF THERE IS ONE(1) CHILD OR DEPENDENT, AND \$400 IF THERE ARE TWO(2) OR MORE.. **NO PAYMENT MAY BE MADE UNDER THE PLAN IF THE SERVICE PROVIDER IS YOUR DEPENDENT FOR FEDERAL INCOME TAX PURPOSES, OR IS YOUR CHILD OR STEPCHILD AND IS UNDER AGE 19.** When requesting reimbursement for a dependent care claim, a Qualifying Dependent is a child under the age of 13, OR, a child, spouse or other dependent who is physically or mentally incapable of self-care and spends at least 8 hours a day in your household.

\_\_\_\_\_  
EMPLOYEE'S SIGNATURE

\_\_\_\_\_  
DATE

08/07 - TD

THIS IS A 2 SIDED FORM

Mail, Fax, or Drop off to:  
Northern Insuring Agency, 171 Margaret Street,  
PO Box 789, Plattsburgh, NY 12901  
Fax (518) 825-0610 Phone (518) 561-7000

## **Guidelines for Unreimbursed Claims**

*All expenses must have been incurred within the current **plan** year. There is a 90 day extension at the end of every plan year during which you may submit claims incurred during the prior plan year.*

*Each claim form must be filled out in full and signed by employee for review, claims not completely filled out will be returned to the employee without further review.*

### Medical Care

*EOB's (**Explanation of Benefits**) are required for any Medical service, which may be covered by your insurance.*

*Invoices are required for any Medical service not covered by insurance; such as eye care, dental, hearing aids, etc.*

*All other reimbursable Medical expenditures will need evidence of authorization by physician stating a specific medical diagnosis. (**Photocopy of original physician's authorization to be attached to each claim form**)*

*Orthodontia expenses must be submitted with a copy of the contract **AND** proof of an active visit, such as payment receipt.*

*OTC's (Over The Counter Medications) will only be reimbursed for a reasonable amount up to a 90-day supply. Stockpiling of OTC's is not allowed and as such any amounts purchased above and beyond that will require a Doctor's note as to why it is medically necessary to be purchasing more than that.*

*Each item submitted for Medical reimbursement **must** have the following: Date(s) of service, Patient name and relationship, Service provider, Amount of charge, EOB if covered by insurance and Nature (Type ) of service*

### Dependent Care

*Dependent Care "PAID" Receipts are required and must include the following: Name(s) of dependent(s), Date(s) of service, Name & signature of provider and Amount of charge. (If receipts from the dependent care provider are not submitted, the claim form **must** be countersigned by the employer.)*

### PHIP

*Each item submitted for PHIP Reimbursement must have the following: Time period of coverage, name of person receiving coverage, insurance carrier, amount of charge, type of insurance and evidence of payment.*

**NOTE:** *Any claims not meeting the above criteria will be rejected. A letter of explanation will accompany reason for denial.*