

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

CHANGE OF ADDRESS ONLY
 New Address _____
 City _____
 State, Zip _____

REIMBURSEMENT REQUEST FORM

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. **Canceled 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 _____

Mail, Fax, or Drop off to:
 Northern Insuring Agency, 171 Margaret Street,
 PO Box 789, Plattsburgh, NY 12901
 Fax (877) 481-2665 Phone (518) 561-7000