

Flexible Spending Account Claim Form

Submit to: NGS American, Inc. P.O. Box 7680 St. Clair Shores, MI 48080-7680 (800) 521-1555 FAX (586) 416-2362

Name _____ SS# _____

Address _____ City _____ State _____ Zip Code _____

Work Telephone Number _____

Please advise your HR Dept of any address changes.

This request is for reimbursement of (check one only):

HEALTH CARE EXPENSES
(Complete Sections A & B)

DEPENDENT CARE EXPENSES (Child Care/Day Care)
(Complete Sections A, B and C)

\$_____ check minimum

A. LIST OF EXPENSES

If an expense is covered under a medical or dental plan, an "Explanation of Benefits" (EOB) form must be attached. If not covered, attach an itemized statement indicating the date of service.
If this is a Dependent Care expense, a receipt indicating dates of service and the amount charged must be attached.

Incomplete and/or unsigned claim form as well as submissions without documentation will be returned.

Date of Service	Provider Name or Type of Service	Amount Requested	NGS USE ONLY
Total Reimbursement Requested		\$	

B. SPOUSE AND DEPENDENT COVERAGE

If expenses were for your spouse or a dependent:

Name:	Birth date:	Relationship:
Name:	Birth date:	Relationship:

C. DEPENDENT CARE INFORMATION (CHILD CARE/DAY CARE)

Please provide Federal Tax I.D. Number or Social Security Number of Dependent Care Provider:

I certify that to the best of my knowledge the expenses listed above have been incurred by me and/or my eligible dependent and will not be reimbursed by any other health benefit plan, nor will I claim this as an income tax deduction or credit on my income tax return. I certify this is an eligible expense, as defined in the Summary Plan Description and the Internal Revenue Code Section 213(d) or IRS Ruling 2003-102 regarding over-the-counter medication and drugs.

The Dependent Care expenses listed above qualify for the federal child care credit, and I will not be eligible to claim the tax credit for any Dependent Care expenses submitted

If I receive reimbursement for an ineligible expense, I agree to indemnify, hold harmless, and reimburse my employer or its agents for any penalty which may be imposed on any of them resulting from such receipt.

Any person who knowingly files a statement of claim containing any false, incomplete or misleading information with intent to defraud or deceive may be guilty of a criminal act punishable under law.

Employee Signature _____ **Date** _____

The following items are some expenses that MAY be reimbursed from your Medical Reimbursement Account:

- Acupuncture
- Alcoholism Treatment
- Ambulance Service
- Artificial Limbs
- Birth Control Pills
- Chiropractor Fees
- Contact Lenses
- Crutches
- Dental Treatment
- Eyeglasses
- Guide Dog
- Hearing Aids
- Laboratory Fees
- Prescription Medicines
- Operations
- Oxygen
- Sterilization
- Transplants
- Wheelchair
- X-ray Fees

Proof of Service for your Medical Reimbursement Account must include the following:

1. Date the service was incurred
2. Description of the service
3. Provider of the service
4. Recipient of the service
5. Amount of the service

The following persons may receive care reimbursed through your Dependent Care Reimbursement Account so that you, if you are single, or you and your spouse, if you are married, can work:

1. Dependent children under the age of 13 living with you
2. Dependent parents living with you
3. Any dependent living with you that is physically or mentally unable to care for himself/herself while you (and your spouse) are at work

The following persons or facilities may NOT provide care reimbursed through your Dependent Care Reimbursement Account:

1. An educational facility
2. A nursing home
3. Another dependent

Proof of service for your Dependent Care Reimbursement Account must include the following:

1. The provider's name
2. The provider's address (even if the care did not take place here)
3. The provider's Tax I.D. or Social Security Number
4. Date(s) of service
5. Amount paid