Northwest Allen County Schools
FLEXIBLE BENEFITS PLAN
REIMBURSEMENT REQUEST

EMPLOYEE NAME SOCIAL SECURITY NUMBER

HOME ADDRESS (Enter address information only if it has changed)

CITY STATE ZIP CODE

THE FOLLOWING REIMBURSEMENT REQUEST RULES APPLY:

1. Receipts (photocopy acceptable) must include the following:
   - Name of provider, type of service/supply provided, date of service/purchase, charge for each service/supply.
2. In place of receipts, for medical expenses an explanation of benefits (EOB) is preferable.
3. Canceled checks **are not** acceptable as a receipt.
4. Supporting documentation must be attached. It will not be returned to you.
5. **Expenses must be incurred during the Plan Year. Date payment is made to provider is not relevant.**

MEDICAL, DENTAL & VISION CARE EXPENSES

Date Incurred	Name of Provider	Describe Expense	Person For Whom Expenses Incurred	Net Amount

Total amount of medical expense **$** _____

CHILD CARE EXPENSES

Date Incurred	Name of Provider	Describe Expense	Person For Whom Expenses Incurred	Net Amount

Total amount of dependent care expenses **$** _____

To the best of my knowledge and belief, my statements in this claim form are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants. I certify that these expenses have not been previously reimbursed under this or any other benefit plan and will not be claimed as an income tax deduction.

EMPLOYEE'S SIGNATURE DATE

MAIL TO: AUTOMATED GROUP ADMINISTRATION, INC. ♦ 7605 WESTFIELD DR ♦ FORT WAYNE, IN 46825
FAX TO: (260) 489-0365
Email to: flex@aga-tpa.com

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