NORTH SHORE BANK

HEALTH CARE REIMBURSEMENT PLAN

Disbursement Request Authorization

Name_____ **Social Security #**_____

Street_____

City, State Zip Code _____

Employer _____ **Home Phone # ( ) _____**

Service Requested for: ____ **Health Care Premium** Monthly Amount Requested: $_____

Provider Name _____

Address _____

_____

Beginning Date : _____ Frequency _____

____ **Out of Pocket Expenses** Amount Requested: $ _____

Person or persons on whose behalf Medical Care Expenses have occurred:

___participant; ___spouse; ___dependent

Provider(s) of care[list names]; type of care; cost of care

Provider _____ Date _____ Expense $ _____

Provider _____ Date _____ Expense $ _____

Provider _____ Date _____ Expense $ _____

Provider _____ Date _____ Expense $ _____

Provider _____ Date _____ Expense $ _____

Type of Disbursement: ____ **ACH**

____ **Transfer to North Shore Bank Checking Account**

Account #: _____

____ **Transfer to North Shore Bank Savings Account**

Account #: _____

By signing below, I certify that the disbursement requested is for service provided to me, my spouse or an eligible dependent and that neither I, nor my spouse or dependent has been reimbursed for these expenses from this Plan or another source. I further certify that the expenses I am requesting reimbursement for are eligible expenses as identified in the Plan Document and may not be claimed as a deduction or credit on any personal income tax return. I further agree to be responsible for all taxes, penalties or other expenses which may arise in the event it shall be later determined that I have received reimbursement for expenses found to be ineligible.

Signed _____ Date _____

Please mail this form to : **North Shore Bank**
15700 W Bluemound Rd
Brookfield, WI 53005

Or Fax to : 262-787-6802

Email: retirement@northshorebank.com