

SERVE AND PROTECT REIMBURSEMENT REQUEST EMPLOYER SERVICES /

LOSS CONTROL DIVISION SFN 62398 (02/2024) 1600 E Century Ave, Ste 1 PO Box 5585 Bismarck ND 58506-5585 **Telephone 800-777-5033** Toll Free Fax 888-786-8695 TTY (hearing impaired) 800-366-6888 Fraud and Safety Hotline 800-243-3331 www.workforcesafety.com

Reimbursement request for paid, full-time firefighters and/or law enforcement officers. An employer may only submit one form per month.

SECTION 1 – Employer information									
Employer's account number	Employer's name								
SECTION 2 – Contact information									
Contact name	Telephone number		Email address						
SECTION 3 – Reimbursement information (If additional employees, list on attached sheet)									
Employee name (First & last name)	Indicate FF- Firefighter	Date of hire	Years of service as	Date of previous	Date of current	Reimbursement request amount			
(i list & last hame)	LE – Law		FF or LE	physical	physical	request amount			
	Enforcement			1 9	1 9				
Total reimbursement request									



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SECTION 4 – Provide previous paid fulltime firefighter or law enforcement employment history. Prior years of service (include employees name, prior employer name, and years of service). (If additional employees, list on attached sheet)									
Employee name	Past employer name		Hire date (mm/dd/year)	End date (mm/dd/year)					
SECTION 5 – Reimbursement Method (choose either credit card or check and indicate the contact information to submit payment)									
Credit									
Contact name	Telephone number	E	mail address	li address					
Check	Supplier id								
Contact name	Telephone number	E	mail address						
Mailing Address	City	S	tate	ZIP code					
SECTION 6 – Signature									
By signing this form, I agree that the information contained here is accurate and true. I further understand that submission of false, misleading or fraudulent information may subject this employer to civil, criminal and administrative penalties.									
Submitted by (Printed name)		Title	· · ·						
Submitted by (Signature)		Date							



Reimbursement Guidelines

Requests for reimbursement are for employers who employ paid, full-time firefighters or law enforcement officers. Requests must be received within 1 year from the date of medical exam.

Medical Exam Reimbursement

- Reimbursement is based on continuous years of service as a paid, full-time firefighter or law enforcement officer regardless of where the service occurred. (see NDCC § 65-01-15.1.3.a).
- The medical exam schedule is:
 - o Upon hire
 - o 1 to 10 years of service, medical exam every 5 years
 - o 11 to 20 years of service, medical exam every 3 years
 - o 21 or more years of service, medical exam every year
- The maximum reimbursement amount is up to \$250 per employee.
- WSI will accept one of the following as supporting documentation.
 - Copy of the paid invoice and proof of payment for medical exam (ex. cleared check, billing statement, or credit card receipt). The invoice must include the provider's name, location, and telephone number; employee's name; date of medical exam; and dollar amount.
 - Copy of the EOB and proof of payment if employer reimbursed the employee for the cost of the medical exam.

Questions relating to the program or reimbursement, contact the program specialist a at 800-777-5033 or email at wsiserveprotect@nd.gov.

