

**CAFETERIA REIMBURSEMENT REQUEST
FOR OVER THE COUNTER MEDICAL EXPENSES.**

EMPLOYED BY:

(Name of Company or Firm)

NAME OF EMPLOYEE:

EMPLOYEE I.D. # (Social Security #):

EMPLOYEE'S ADDRESS:

RETURN TO:

**BERN & PUGH, INC.
1000 25th STREET NORTH
GREAT FALLS, MT 59401**

**FAX: (406)727-4979
PHONE: (406)727-4969
1-800-406-4097**

claims@bernpugh.com

INDICATE IF THIS IS A CHANGE OF ADDRESS

I HEREBY SUBMIT THE FOLLOWING TO BE PAID FROM MY CAFETERIA PLAN

CLAIM #1

(Name of Patient)

(Medical Condition)

(Items Purchased)

(Date of Purchase)

(Store)

(Amount to be Paid from Cafeteria Fund)

DOLLAR AMOUNT MUST BE SPECIFIED

CLAIM #2

(Name of Patient)

(Medical Condition)

(Items Purchased)

(Date of Purchase)

(Store)

(Amount to be Paid from Cafeteria Fund)

DOLLAR AMOUNT MUST BE SPECIFIED

DOCUMENTATION OF EXPENSES.

Any participant applying for reimbursement under this plan shall submit to the Administrator an itemized sales slip with prescription or letter of Medical Necessity. Photocopies of itemized statements will be accepted. The prescription or letter of Medical Necessity is good for one year.

OTHER INSURANCE

Reimbursement under this plan shall be made by the Company only in the event and to the extent that such reimbursement or payment is not provided for under any insurance policy or policies, whether owned by the corporation or by the participant, or under any other health or accident plan. In the event there is such a policy or plan in effect, providing for coverage under such policy or plan, the corporation shall be relieved of any liability hereunder.

I CERTIFY THESE BILLS ARE ELIGIBLE UNDER MY CAFETERIA PLAN.

SIGNATURE

OF EMPLOYEE

HOME PHONE

WORK PHONE

THESE ARE REQUIRED

Prescription or Letter of Medical Necessity on File