CAFETERIA REIMBURSEMENT REQUEST
FOR PRESCRIPTIONS, MEDICAL, DENTAL, VISION, OR ORTHODONTIA EXPENSES.

EMPLOYED BY: _____
(Name of Company or Firm)

NAME OF EMPLOYEE: _____

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

EMPLOYEE'S ADDRESS: _____

_____

RETURN TO:

BERN & PUGH, INC.
1 FIFTH 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

MEDICAL, DENTAL, VISION OR ORTHODONTIA EXPENSES FOR:

CLAIM #1
_____ (Name of Patient)
_____ (Name of Doctor or Provider)
_____ (Date (s) of Service)
_____ (Amount to be Paid from Cafeteria Fund)

DOLLAR AMOUNT MUST BE SPECIFIED

CLAIM #2
_____ (Name of Patient)
_____ (Name of Doctor or Provider)
_____ (Date (s) of Service)
_____ (Amount to be Paid from Cafeteria Fund)

DOLLAR AMOUNT MUST BE SPECIFIED

CLAIM #3
_____ (Name of Patient)
_____ (Name of Doctor or Provider)
_____ (Date (s) of Service)
_____ (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 all hospitalization, doctor, optical, or other medical bills. These bills must list date(s) of service, name of provider, description of service(s) rendered and name of patient. Photocopies of itemized statements will be accepted.

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. The Participant will not seek reimbursement through any other source

I CERTIFY THESE BILLS ARE ELIGIBLE UNDER MY CAFETERIA PLAN.

SIGNATURE OF EMPLOYEE _____ HOME PHONE _____ WORK PHONE _____

DATE: _____

THESE ARE REQUIRED