

**HEALTH REIMBURSEMENT ARRANGEMENT (HRA) REQUEST
FOR PRESCRIPTIONS, MEDICAL, DENTAL, VISION, OR ORTHODONTIA EXPENSES.**

EMPLOYED BY:

RETURN TO:

(Name of Company or Firm)

**BERN & PUGH, INC.
1 FIFTH STREET NORTH
GREAT FALLS, MT 59401**

NAME OF EMPLOYEE:

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

EMPLOYEE'S ADDRESS:

**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.

I CERTIFY THESE BILLS ARE ELIGIBLE UNDER MY CAFETERIA PLAN.

SIGNATURE

HOME PHONE _____

OF EMPLOYEE _____

WORK PHONE _____

DATE _____

THESE ARE REQUIRED