Williams Brothers Medical Reimbursement Plan Claim Form

EMPLOYEE NAME: ______________________ ID# (Social Security #): ____________________
EMPLOYEE'S ADDRESS: ____
____

☐ PLEASE INDICATE IF THIS IS A CHANGE OF ADDRESS

MEDICALEXPENSES FOR: Medical, Dental, Vision or Orthodontia

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 Bern & Pugh, Inc. all hospitalization, doctor, dental, optical, or other medical bills. These bills must list date(s) of service, name of provider, description of services(s) rendered, and name of patient. Photocopies of itemized statements will be accepted.

OTHER INSURANCE:
Reimbursement under this plan shall be made by Williams Brothers, 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 Administrator, or by the participant, or under any other health and accident plan. In the event there is such a policy or plan in effect, providing for coverage under such a policy or plan, the Administrator shall be relieved of any liability hereunder. Any amounts paid by Williams Brothers Medical Reimbursement Plan that are later paid or reimbursed by any other source need to be repaid to the Plan.

I CERTIFY THESE BILLS ARE ELIGIBLE BENEFITS UNDER WILLIAMS BROTHERS MEDICAL REIMBURSEMENT PLAN AND HAVE NOT AND WILL NOT BE PAID OR REIMBURSED FROM ANY OTHER SOURCE.

SIGNATURE OF EMPLOYEE ______________________________ HOME PHONE __________
WORK PHONE __________

DATE ______________________________

THESE ARE REQUIRED

RETURN COMPLETED FORM TO:
BERN & PUGH, INC.
1 FIFTH STREET NORTH
GREAT FALLS, MT 59401
FAX: (406) 727-4979 or Email: claims@bernpugh.com

Revised April 2010