

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

EMPLOYED BY:

\_\_\_\_\_  
(Name of Company or Firm)

RETURN TO:

**BERN & PUGH, INC.  
1000 25<sup>th</sup> 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**

**OF EMPLOYEE** \_\_\_\_\_

HOME PHONE \_\_\_\_\_

WORK PHONE \_\_\_\_\_

**THESE ARE REQUIRED**