NATIONAL CENTER FOR APPROPRIATE TECHNOLOGY
MEDICAL REIMBURSEMENT PLAN CLAIM FORM

NAME OF EMPLOYEE: ______________________________

EMPLOYEE'S ADDRESS: ______________________________

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☐ PLEASE INDICATE IF THIS IS A CHANGE OF ADDRESS

ATTACH EXPLANATION OF BENEFITS TO THIS FORM.

DOCUMENTATION OF EXPENSES:

Any participant applying for reimbursement under this plan shall submit to Bern & Pugh, Inc. all corresponding Explanation of Benefits. Only amounts applied to the deductible or coinsurance are eligible for reimbursement.

Please check the box below if you have had pharmacy claims since January 1, 2010 and have not received an Explanation of Benefits.

☐ Pharmacy Claim – for ______________________________

OTHER INSURANCE:

Reimbursement under this plan shall be made by the Administrator 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 National Center for Appropriate Technology 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 NATIONAL CENTER FOR APPROPRIATE TECHNOLOGY'S MEDICAL REIMBURSEMENT PLAN AND HAVE NOT AND WILL NOT BE PAID OR REIMBURSED FROM ANY OTHER SOURCE.

SIGNATURE OF EMPLOYEE ______________________________ HOME PHONE ______________ WORK PHONE ______________

RETURN COMPLETED FORM TO:

BERN & PUGH, INC.
1000 25TH STREET NORTH
GREAT FALLS, MT 59401
OR FAX (406) 727-4979
OR EMAIL claims@bernpugh.com

AUTHORIZATION FOR RELEASE OF INFORMATION:

I hereby request and authorize Bern & Pugh, Inc. to process this claim through my Section 125 cafeteria plan. I understand that the information to be disclosed is protected by law and that the same information may be re-disclosed by the recipient and may no longer be protected by the same law(s) that applied in the first instance. I understand that this authorization only applies to the claims attached. Claims information will not be processed through the Section 125 cafeteria plan without my attached signature below.

SIGNATURE OF EMPLOYEE ______________________________ Date ______________