

CAFETERIA REIMBURSEMENT REQUEST  
FOR CHILD CARE EXPENSES

EMPLOYED BY: Cut Bank Schools  
(Name of Company or Firm)  
NAME OF EMPLOYEE: \_\_\_\_\_  
EMPLOYEE I.D. # (Social Security #) \_\_\_\_\_  
EMPLOYEE'S \_\_\_\_\_  
ADDRESS \_\_\_\_\_

Return to:

Northwest Administrators  
PO Box 3105  
Great Falls, MT 59403  
Fax (406) 761-0619  
Telephone (406) 453-7026  
1-800-406-1027

( ) PLEASE INDICATE IF THIS IS AN ADDRESS CHANGE

I HEREBY SUBMIT THE FOLLOWING TO BE PAID FROM MY CAFETERIA PLAN.  
DEPENDENT CARE EXPENSE FOR:

\_\_\_\_\_ (Name of Dependent)  
\_\_\_\_\_ (Name of Babysiter/Nursery)  
\_\_\_\_\_ (Date(s) of Service)  
\_\_\_\_\_ (Amount Be Paid From Cafeteria Fund)

DOCUMENTATION OF EXPENSES:

Any participant applying for reimbursement under this plan shall submit to the Administrator, at least quarterly, all claims for reimbursement. This form must be accompanied by documentation of Incurred Child Care Expenses. Documentation must show, Dates of Service, Child Care Providers Name, Amount paid.

I CEDRTIFY THESE EXPENSESS ARE ELIGIBLE BENEFITS UNDER MY CAFETERIA PLAN.

\_\_\_\_\_  
SIGNATURE OF EMPLOYEE

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

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