CAFETERIA REIMBURSEMENT REQUEST

USE ONLY FOR NON PRESCRIPTION OVER THE COUNTER MEDICAL EXPENSES

EMPLOYED BY: Cut Bank School District

NAME OF EMPLOYEE: ______________________________

EMPLOYEE ID #(SOCIAL SECURITY #) _________________

EMPLOYEE ADDRESS: ______________________________

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INDICATE OF THIS IS A CHANGE OF ADDRESS [ ]

I HEREBY SUBMIT THE FOLLOWING ITEMS TO BE PAID FROM MY

CAFETERIA ACCOUNT

CLAIM #1 ____ **MEDICAL CONDITION**

____ **ITEM(S) PURCHASED**

____ **FOR WHOM**

DOLLAR ___________________________________ **AMOUNT SPECIFIED**

____ **STORE (ITEMIZED SALES SLIP ATTACHED)**

CLAIM #2 ____ **MEDICAL CONDITION**

____ **ITEM(S) PURCHASED**

____ **FOR WHOM**

DOLLAR ___________________________________ **AMOUNT SPECIFIED**

____ **STORE (ITEMIZED SALES SLIP ATTACHED)**

OTHER INSURANCE:
Reimbursement under this plan shall be made by the company only in the event and to the extend that such reimbursement or payment is not provided for under any insurance policy or policies, whether owned by the corporation of by the participant, or under any health or accident plan. In the event there is such a policy or plan in effect, providing for coverage under such policy of plan, the corporation shall be relieved of any liability hereunder.

I CERTIFY THE ITEMS SUBMITTED FOR REIMBURSEMENT ARE ELIGIBLE UNDER M Y CAFETEIA PLAN

EMPLOYEE SIGNATURE ____
Home Phone # _________________________ **Work Phone #** ____________________